87-380

No.

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1987

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

TALLAHASSEE MEMORIAL REGIONAL MEDICAL CENTER, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

DONALD B. AYER
Acting Solicitor General
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12 pp

QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

PARTIES TO THE PROCEEDING

In addition to the petitioner named in the caption, William Roper, Administrator, Health Care Financing Administration,* was a defendant in the district courts and is a petitioner in this Court.

In addition to the respondents named in the caption, the following were plaintiffs in the district courts and are respondents in this Court: Parkway Medical Center; Palm Beach Gardens Community Hospital; Clearwater Community Hospital; Amisub of Florida; Baptist Hospital of Miami; Abbey Hospital and Medical Center; Bascom Palmer Eye Institute; Bethesda Memorial Hospital; Boca Raton Community Hospital; Broward General Medical Center; Cedars Medical Center; Doctors General Hospital; Doctors Hospital of Lake Worth; Florida Keys Memorial Hospital; Florida Medical Center; Highlands General Hospital; Holy Cross Hospital, Inc.; Imperial Point Medical Center; Jackson Memorial Hospital; James Archer Smith Hospital; Larkin General Hospital; Los Olas General Hospital; Martin Memorial Hospital; Mercy Hospital, Inc.; North Broward Hospital; Palm Beach-Martin County Medical Center; Pembroke Pines General Hospital; Walker Memorial Hospital; Jay Hospital; Jackson Hospital; Gadsden Memorial Hospital; Doctor's Memorial Hospital; Santa Rosa Hospital; Shands Teaching Hospital and Clinic.

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* Carolyne K. Davis was Administrator of the Health Care Financing Administration at the time the complaints were filed. Her successor is automatically substituted as a petitioner by operation of Rule 40.3 of the Rules of this Court.

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v.

TALLAHASSEE MEMORIAL REGIONAL MEDICAL
CENTER, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services and the Administrator, Health Care Financing Administration, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit in these consolidated cases.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-64a) is reported at 815 F.2d 1435. The opinion of the United States District Court for the Southern District of Florida on the motions for summary judgment (App., *infra*, 65a-72a) is reported at 614 F. Supp. 564. That court's opinion on the motions to dismiss, its final judgment, and its opinion on the motion for reconsideration (App., *infra*, 73a-80a, 81a-83a, 84a-85a) are unreported. The opinion and final judgment of the United States District Court for the Northern District of Florida (App., *infra*, 86a-92a) are unreported. The opinion of the Provider Reimbursement Review Board (App., *infra*, 93a-100a) is unreported.

JURISDICTION

The judgment of the court of appeals (App., *infra*, 101a-102a) was entered on May 5, 1987. On July 28, 1987, Justice White extended the time for filing a petition for a writ of certiorari to and including September 2, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES INVOLVED

The relevant provisions of the Medicare statute are set forth at pages 103a-106a of the appendix to this petition.

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services (42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A)).[1] Over the course of the year, the Secretary made payments to a provider based upon an estimate of the amounts owed to the provider. 42 U.S.C. 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submitted a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and sup-

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[1] These cases concern payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c).

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

plemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheets cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims.

The cost report is submitted to the provider's "fiscal intermediary" for review.[3] The intermediary audits the cost report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803.[4]

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timely basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB) (42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835).[5] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse

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[3] The intermediary, which is generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128.

[4] The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

[5] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.S.C. (& Supp. III) 1395*oo*(a)(2) and (3)).

> to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); 42 C.F.R. 405.1875, 405.1877.

The statute establishes a second, more expeditious route into court in certain circumstances. A provider may obtain direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.[6]

2. Respondents all are certified as providers of health services under the Medicare program. The substantive issue in this case in the courts below was the validity of a regulation promulgated by the Secretary in 1979, which established the level of Medicare reimbursement for medical malpractice insurance costs. Thirty respondents "ignored the 1979 rule and filled out their cost reports [for fiscal years covered by the 1979 rule] as if it did not exist," claiming reimbursement for malpractice insurance costs under the pre-1979 rule; the fiscal intermediaries disallowed the claims to the extent they exceeded the reimbursement permitted under the 1979 rule. App., *infra*, 10a.

Five respondents, Santa Rosa Hospital, Jackson County Hospital, Shands Teaching Hospital and Clinic, Mercy Hospital, and Abbey Hospital and Medical Center,

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[6] A final decision may be reopened by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

followed the 1979 rule in seeking reimbursement for medical malpractice costs, and did not request reimbursement at the higher, pre-1979 rate. These hospitals thus "self-disallowed" medical malpractice costs to the extent those costs exceeded the reimbursement permitted under the 1979 rule. App., *infra*, 10a-11a. The court of appeals observed that "[b]ecause [these hospitals] did not file under the pre-1979 rule * * * their fiscal intermediaries did not need to adjust their cost reports downward to bring them into conformity with the 1979 rule. Thus, the [Notices of Program Reimbursement] for these five hospitals did not reflect any adjustments or denials of claims" (*id.* at 11a).

All of the hospitals sought review of the intermediaries' determinations before the Provider Reimbursement Review Board. With respect to the 30 hospitals that had raised the malpractice insurance reimbursement issue before their intermediaries, the Board concluded that it was appropriate to authorize direct judicial review of the matter pursuant to 42 U.S.C. (& Supp. III) 1395*oo*(f)(1) because there were no factual matters in dispute and the Board did not have authority to determine the validity of the 1979 regulation. See App., *infra*, 10a-12a.

The Board concluded that it lacked jurisdiction over the claim of the five hospitals that failed to raise the malpractice reimbursement issue before their intermediary (App., *infra*, 93a-100a). It observed that "the malpractice issue was not raised in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (*id.* at 93a).

The Board stated that "[w]ithout any notice of a claimed cost on a cost report, the intermediary is precluded from

considering the matter and making any final determination for that particular item which especially applies to self-disallowed costs. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. Thus, the Board's jurisdiction flows from the intermediary's [Notice of Program Reimbursement] with respect to the filed cost report, and the disputes arising from costs claimed in the cost report" (App., *infra*, 95a). "When the provider files a cost report, the particular cost must be claimed therein or [the provider must] state its claim and disclose its position on an issue so the intermediary can consider and make a final determination which was not done in this case. This is essential to Board jurisdiction" (*id.* at 96a).

The hospitals sought judicial review in two district courts, the United States District Court for the Southern District of Florida and the United States District Court for the Northern District of Florida. See App., *infra*, 65a-80a, 86a-92a. Both courts invalidated the 1979 rule regarding reimbursement for medical malpractice insurance costs (*id.* at 65a-72a, 89a-90a). The courts reversed the Board's determination regarding the scope of its jurisdiction. They concluded that "[t]here is no statutory requirement that in the course of filing the 'cost report' * * * a provider must also 'raise an issue' "; a claim is "within the jurisdiction of the Board" as long as the cost was listed in the cost report. *Id.* at 77a-78a; see also *id.* at 88a.

3. The court of appeals upheld the district courts' conclusion that the five self-disallowing hospitals are entitled to challenge the 1979 rule (App., *infra*, 1a-64a).[7] The

[7] With respect to the substantive challenge to the 1979 reimbursement rule, the court upheld the district courts' invalidation of the rule and rejected the Secretary's contention that a rule promulgated in 1986 applied retroactively to the hospitals' claims. The court concluded that the hospitals are entitled to reimbursement under the pre-1979 rule. App., *infra* 20a-43a.

court of appeals found that the statutory provision relevant to this question is 42 U.S.C. (& Supp. III) 1395*oo*(f)(1), the provision of the Medicare statute that addresses judicial review. The court observed that the first right to judicial review set forth in Section 1395*oo*(f)(1) relates to review of "*decisions* of the [PRRB]" (App., *infra,* 52a (emphasis in original)). The availability of review under this provision is therefore "affected by [42 U.S.C. 1395*oo*(d)], which defines the scope of the decision-making power of the PRRB" (*ibid.*).

The second grant of judicial review authorizes expedited judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question" (42 U.S.C. (& Supp. III) 1395*oo*(f)(1)). The statute states that "[i]f a provider of services" is entitled to a hearing before the Board under 42 U.S.C. (& Supp. III) 1395*oo*(a), it may place before the Board a request for immediate judicial review.

The court of appeals stated that the provision for expedited judicial review "does *not* involve *decisions* of the PRRB, but rather permits review when the PRRB 'determines' that it does not have the authority to make a decision about an issue"; the court concluded that the statutory limitations upon the Board's authority to issue a decision altering the Notice of Program Reimbursement are irrelevant in ascertaining the availability of judicial review under this portion of the statute (App., *infra,* 53a (emphasis in original)). The court stated that "in cases where the PRRB does not have the authority to decide a question of law or regulation, a provider can obtain judicial review by fulfilling the requirements of [Section 1395*oo*(a)] and petitioning for a determination * * * that the PRRB lacks the needed authority" (*ibid.*). The court indicated that the provider need not raise a reimbursement

claim before its intermediary in order to satisfy these requirements (*id.* at 53a, 58a-61a).[8]

Judge Edmondson dissented with respect to the self-disallowance issue (App., *infra,* 63a-64a). He observed that expedited judicial review is available as to " 'any *action of a fiscal intermediary* which involves a question of law or regulation relevant to the matters in controversy' " (*id.* at 63a, quoting 42 U.S.C. (& Supp. III) 1395*oo*(f)(1) (emphasis added by Judge Edmondson)). Judge Edmondson stated that "[t]he five 'self-disallowing' hospitals in this case never requested their fiscal intermediary for reimbursement under the pre-1979 malpractice rule. Instead, they requested the lesser reimbursement available under the 1979 rule" (*id.* at 64a). Thus "the fiscal intermediary took no action with respect to the 'self-disallowing' hospitals' claims (now advanced to [the court of appeals]) for excess reimbursement available under the pre-1979 rule"; and, "[i]n the absence of such action by the fiscal intermediary, federal courts lack jurisdiction to review the self-disallowing hospitals' claims" (*ibid.* (footnote omitted)).

ARGUMENT

The question presented in this case is the same as the question presented in *Bethesda Hospital Ass'n* v. *Bowen,* petition for cert. pending, No. 86-1764.[9] Although the

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[8] The court noted that another panel of the Eleventh Circuit had concluded in *North Broward Hospital District* v. *Bowen,* 808 F.2d 1405 (1987), petition for cert. pending, No. 86-1986, that the Board lacked jurisdiction over reimbursement claims that had not been raised before the intermediary. The court of appeals here explained that the different results were attributable to the difference between the two types of judicial review available under Section 1395*oo*(f)(1). App., *infra,* 44a-45a.

[9] We have served petitioner's counsel with a copy of our response to the petition in *Bethesda Hospital Ass'n.*

legal reasoning of the court below differs somewhat from that employed by the court of appeals in *Bethesda Hospital Ass'n,* the court of appeals here acknowledged (App., *infra,* 56a) that its holding conflicts with the holding in *Bethesda Hospital Ass'n.*[10] At bottom, the question in both cases is whether the Medicare statute requires a provider to raise a reimbursement claim before the intermediary in order to obtain further administrative or judicial review. For the reasons stated in our response (at 7-11) to the petition for a writ of certiorari in *Bethesda Hospital Ass'n,* we believe that the court of appeals in that case correctly held that a provider must raise a reimbursement claim before its intermediary in order to obtain further review of that claim. Because of the conflict among

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[10] The court below acknowledged that the Provider Reimbursement Review Board may authorize a provider to seek expedited judicial review only if the provider's request for a hearing is properly before the Board pursuant to 42 U.S.C. (& Supp. III) 1395*oo*(a). By holding that the five self-disallowing hospitals are entitled to judicial review of their claims here, the court concluded that the requirements of Section 1395*oo*(a) may be satisfied even though a provider fails to raise its claim before the intermediary. The courts of appeals that have found presentation of the claim to the intermediary to be a condition precedent to further review have interpreted Section 1395*oo*(a) in precisely the opposite manner. See our response (at 3) in *Bethesda Hospital Ass'n.*

Moreover, the statutory provision relied upon by the court below authorizes expedited judicial review of an "action of the fiscal intermediary" (42 U.S.C. (& Supp. III) 1395*oo*(f)(1)); the court below found this requirement satisfied despite the absence of any action by the intermediary with respect to respondents' self-disallowed reimbursement claims. In *Bethesda Hospital Ass'n,* by contrast, the court of appeals concluded that the statute authorizing the Board to review a "final determination of the fiscal intermediary" (42 U.S.C. 1395*oo*(d)) requires the presentation of a reimbursement claim to the intermediary as a condition precedent to Board action. These conflicting interpretations of the parallel statutory language plainly rest upon different views of the administrative review scheme established by the Medicare statute.

the courts of appeals and the importance of the issue, however, we have suggested that the Court should grant the petition for a writ of certiorari in *Bethesda Hospital Ass'n.*

CONCLUSION

The petition for a writ of certiorari should be held and disposed of as appropriate in light of the disposition of *Bethesda Hospital Ass'n* v. *Bowen,* petition for cert. pending, No. 86-1764.

Respectfully submitted.

DONALD B. AYER
*Acting Solicitor General**

AUGUST 1987

* The Solicitor General is disqualified in this case.

APPENDIX A

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT

Nos. 85-3839, 85-5131

TALLAHASSEE MEMORIAL REGIONAL MEDICAL CENTER, ET AL., PLAINTIFFS-APPELLEES

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

BAPTIST HOSPITAL OF MIAMI, ET AL., PLAINTIFFS-APPELLEES/CROSS-APPELLANTS

v.

OTIS BOWEN, SECRETARY OF HEALTH & HUMAN SERVICES, DEFENDANT-APPELLANT/CROSS-APPELLEE

PARKWAY MEDICAL CENTER, PALM BEACH GARDENS COMMUNITY HOSPITAL, CLEARWATER COMMUNITY HOSPITAL, AND AMISUB OF FLORIDA, PLAINTIFFS-APPELLEES/CROSS-APPELLANTS

v.

OTIS BOWEN, ETC., ET AL., DEFENDANTS-APPELLANTS/CROSS-APPELLEES

Appeal from the United States District Court for the Northern District of Florida

Appeals from the United States District Court for the Southern District of Florida

May 5, 1987

Before CLARK, EDMONDSON and KEITH*, Circuit Judges.

CLARK, Circuit Judge:

In this complex case, the plaintiff hospitals challenged the application of a 1979 regulation, promulgated by the defendant Secretary of Health and Human Services, regarding reimbursement under Medicare of medical malpractice insurance costs. The district courts below invalidated the 1979 rule, 614 F.Supp 564, and awarded reimbursement under the pre-1979 regulation. During the briefing in the Secretary's appeal to this court, the Secretary promulgated a new regulation to replace the invalid 1979 rule. The Secretary now argues that this case is moot because the 1979 rule is no longer in effect. The Secretary also argues that five hospitals that "self-disallowed" certain costs should be denied relief. For reasons set out in this opinion, we affirm the rulings of the district courts below and order the Secretary to pay all of the hospitals under the pre-1979 regulations.

I. FACTUAL AND PROCEDURAL BACKGROUND

To understand the issues presented in this case, it is necessary to review in some detail the underlying facts of the case and the progress of the litigation, both in the district courts below and in this court.

A. *The Medicare Program*

In 1965, Congress enacted the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1982), to provide a comprehensive system of health care

* Honorable Damon J. Keith, U.S. Circuit Judge for the Sixth Circuit, sitting by designation.

for the elderly and infirm.[1] Under Part A of the program,[2] Medicare provides payments to qualified hospitals to reimburse them for medical care provided to Medicare beneficiaries. A hospital may participate in the Medicare program as a "provider of services" by entering into a "provider agreement" with the Secretary of Health and Human Services (the "Secretary"). *Id.* § 1395x(e), (u). The provider (i.e., the hospital) is entitled to payment of the lesser of the "reasonable cost" or the "customary charges" of hospital services provided to Medicare beneficiaries. *Id.* § 1395f(b)(1).[3] A provider receives its Medicare reimbursements directly from the Secretary or, more commonly, through a "fiscal intermediary" appointed by the provider. The fiscal intermediary, usually a private insurance company, acts as an agent of the Secretary for the purpose of reviewing the provider's claim for reimbursement. *Id.* § 1395h.

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[1] This review of the Medicare procedures is drawn in large part from Judge Young's concise summary of the reimbursement scheme in *St. Luke's Hospital v. Secretary of Health and Human Services,* 632 F.Supp. 1387 (D.Mass.1986), *aff'd in part, rev'd in part and vacated,* 810 F.2d 325 (1st Cir.1987). For a detailed explanation of the malpractice regulations, see *Lloyd Noland Hospital and Clinic v. Heckler,* 762 F.2d 1561 (11th Cir.1985).

[2] The Medicare Act is divided into three parts. At issue in this case is Part A, codified at 42 U.S.C. §§ 1395c to 1395i-2, which provides insurance for hospitalization and medical care for the elderly and disabled. Part B, codified at 42 U.S.C. §§ 1395j to 1395w, provides voluntary insurance for supplemental medical care for qualified recipients. Part C, 42 U.S.C. §§ 1395x to 1395xx, includes miscellaneous provisions applicable to Parts A and B.

[3] Because of certain 1983 amendments to the Social Security Act, the "reasonable cost" reimbursement scheme has been largely phased out. 42 U.S.C.A. § 1395ww (West 1986). Since October, 1, 1986, only a small number of the hospitals in the country use the reimbursement scheme described here. *Id.* § 1395ww(d)(1)(B). For a description of the new payment plan, see *Charter Medical Corp. v. Bowen,* 788 F.2d 728, 730-31 (11th Cir.1986). *See also Washington Hospital Center v. Bowen,* 795 F.2d 139, 141-42 (D.C.Cir.1986) (contrasting both reimbursement schemes).

The process by which the final amount of reimbursement is determined is quite complex. The payment process begins when the provider files, at the end of each "cost year," a cost report with its fiscal intermediary. 42 C.F.R. § 405.406(b) (1985). This report sets forth the costs of all services provided to Medicare patients during the year. The fiscal intermediary analyzes and audits the cost report, and issues a Notice of Program Reimbursement ("NPR"), which sets forth the amount of reimbursement to which the intermediary believes the provider is entitled. This NPR reflects any costs claimed by the provider but disallowed by the intermediary. *Id.* § 405.1803. If the provider is dissatisfied with the fiscal intermediary's determination (and if certain jurisdictional requirements are met), it may appeal the determination to the Provider Reimbursement Review Board (the "PRRB"). 42 U.S.C. § 1395oo(a). The PRRB has the power to affirm, reverse, or modify a determination made by a fiscal intermediary. *Id.* § 1395oo(d). Within 60 days after a final decision of the PRRB, the Secretary may review, on his own motion or at the request of the provider, the decision of the PRRB. *Id.* § 1395oo(f)(1). A provider dissatisfied with a final decision of the PRRB or Secretary may seek review of the decision in the federal district court in which the provider is located, or in the District Court for the District of Columbia. *Id.* The district court's review is made in accordance with the Administrative Procedure Act, and is based on the administrative record. 5 U.S.C. § 706 (1982).

The exact language of certain subsections of 42 U.S.C. § 1395oo, which establishes and controls the PRRB, is highly relevant to portions of this appeal. In order to appeal to the PRRB, a provider must meet certain deadlines and minimum amount-in-controversy requirements:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by [the PRRB] . . . if—

> (1) such provider –
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, . . .
>
> . . . .
>
> (2) the amount in controvery is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's [or Secretary's] final determination. . . .

Id. § 1395oo(a).[4] On appeal, the provider can present evidence and witnesses at a hearing before the PRRB.

> A decision by the [PRRB] shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the [PRRB] and shall be supported by substantial evidence when the record is viewed as a whole. The [PRRB] shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not con-

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[4] A group of providers can appeal to the PRRB together even if each individual provider does not have over $10,000 at issue, so long as the group appeal as a whole puts at least $50,000 into controversy. 42 U.S.C. § 1395oo(b). This case represents the appeals of three groups of hospitals, each of which easily meets the $50,000 requirement; most hospitals in the groups would meet the $10,000 requirement for individual appeals.

> sidered by the intermediary in making such final determination.

Id. § 1395oo(d). After decision by the PRRB, there are two bases for appeal to a district court:

> Providers shall have the right to obtain judicial review of any final decision of the [PRRB], or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the [PRRB] or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty day of the date on which notification of such determination is received.

Id. § 1395oo(f)(1).[5]

B. ***Medical Malpractice Insurance Under Medicare***

Since its inception, the Medicare program reimbursed hospitals and other providers according to the amount the facilities were used by Medicare patients. Under the accounting procedures used, costs are grouped into cost categories. Medical malpractice insurance, along with other administrative and insurance expenses, was grouped under the General and Administrative cost category. These "G & A" costs were allocated to a "cost center" within the hospital, such as the emergency room. Medicare reimbursed the hospital for a portion of each cost center's G & A costs, based on the Medicare patient utilization rate

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[5] The full text of subsection (f)(1) is reproduced, with amendments indicated, in Appendix I of this opinion.

for that center. Ultimately, in very simple terms, a hospital in which 40% of the patients were Medicare beneficiaries was reimbursed for 40% of its malpractice insurance premiums.

In 1979, in response to the increased cost of malpractice insurance, the Secretary promulgated a new regulation which removed malpractice insurance from the G & A cost reimbursement scheme. 44 Fed. Reg. 31641-42, *codified at* 42 C.F.R. § 405.452(b)(1)(ii), *recodified to* 42 C.F.R. § 405.452(a)(1)(ii). Under the 1979 scheme, if a hospital had actually paid any malpractice claims over the preceding five years, it would be reimbursed for insurance premiums by the percentage of those claims that were paid to Medicare patients. If a hospital had not paid any malpractice claims in the preceding five years, the hospital would be reimbursed for insurance premiums based on an average national figure set at 5.1%. Thus, a hospital with 40% Medicare patients might be reimbursed for only 5.1% of its malpractice costs.[6]

Soon after the promulgation of the 1979 regulation, hospital associations around the country, representing over 6,000 hospitals (including those in the case now before this court), joined in a direct challenge to the new regulations, arguing that, among other problems, the regulations were not issued in conformity with the requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 500 (1982). The Secretary raised jurisdictional objections, and the Tenth Circuit dismissed the suit based on 42 U.S.C. § 405(h), which bars general federal question

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[6] In *Lloyd Noland Hospital and Clinic v. Heckler,* 762 F.2d 1561 (11th Cir.1985), for example, one hospital had 32% Medicare patients and the other had 42%. Because of their malpractice claim history, both were reimbursed at the national rate of 5.1%. This made a difference of over $13,000 for the first hospital, and over $10,000 for the second. *Id.* at 1564. In this case, the amounts in controversy range from a few thousand dollars to over one hundred thousand dollars; the Baptist Hospital of Miami, for instance, is seeking additional reimbursement of $103,569. Appendix A, Complaint, *Baptist Hospital of Miami v. Heckler,* 614 F.Supp. 564 (S.D.Fla.1984).

jurisdiction in actions against the Secretary to recover on any claim arising under the Social Security Act. *Hadley Memorial Hospital v. Schweiker*, 689 F.2d 905 (10th Cir.1982). The Tenth Circuit held that the hospitals, to challenge the regulation, would have to go through the administrative appeals process set out in the Medicare statutes, and, after final decision by the PRRB, the hospitals could bring suit in the district court in which they were located. *Id.* at 910.

After the *Hadley* decision, hospitals all across the country exhausted their administrative appeals, and brought suits challenging the 1979 regulation; numerous lawsuits, many involving groups of hospitals, were filed and began filtering their way through the federal courts. Over the past few years, at least eight circuit courts and many district courts have invalidated the 1979 regulation, while no court in the country has upheld the rule.[7]

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[7] *See, e.g., Cumberland Medical Center v. Secretary of Health and Human Services,* 781 F.2d 536 (6th Cir.1986); *Bedford County Memorial Hospital v. Health and Human Services,* 769 F.2d 1017 (4th Cir.1985); *Menorah Medical Center v. Heckler,* 768 F.2d 292 (8th Cir.1985); *DeSoto General Hospital v. Heckler,* 766 F.2d 182 (5th Cir.), *modified,* 776 F.2d 115 (5th Cir. 1985); *Lloyd Noland Hospital and Clinic v. Heckler,* 762 F.2d 1561 (11th Cir.1985); *St. James Hospital v. Heckler,* 760 F.2d 1460 (7th Cir.), *cert. denied,* ___ U.S. ___, 106 S.Ct. 229, 88 L.Ed.2d 228 (1985); *Humana of Aurora, Inc. v. Heckler,* 753 F.2d 1579 (10th Cir.), *cert. denied,* ___ U.S. ___, 106 S.Ct. 180, 88 L.Ed.2d 149 (1985); *Abington Memorial Hospital v. Heckler,* 750 F.2d 242 (3d Cir.1984), *cert. denied,* ___ U.S. ___, 106 S.Ct. 180, 88 L.Ed.2d 149 (1985); *Walter O. Boswell Memorial Hospital v. Heckler,* 628 F.Supp. 1121 (D.D.C.1985); *Albany General Hospital v. Heckler,* 584 F.Supp. 614 (D.Ore.1984), *appeal stayed pending disposition of above referenced petitions to Supreme Court for certiorari,* No. 84-3865 (9th Cir. Aug. 5, 1985), *remanded without opinion,* 796 F.2d 478 (9th Cir.1986); *St. Joseph's Hospital v. Heckler,* 583 F.Supp. 1545 (D.Ariz.1984), *appeal stayed pending disposition of above referenced petitions to Supreme Court for certiorari,* No. 84-2168 (9th Cir. August 5, 1985), *remanded without opinion,* 796 F.2d 479 (9th Cir.1986).

A number of cases, including the three consolidated into this appeal, were filed in this circuit challenging the 1979 rule. In June of 1985, the circuit addressed and resolved the question in the first case that reached it, *Lloyd Noland Hospital and Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985). In *Lloyd Noland,* the court invalidated the rule as in violation of the Administrative Procedures Act ("APA"), 5 U.S.C. § 500. The court found that the Secretary had promulgated the rule with insufficient response to comments and criticisms, *see id.* § 553(c), and the Secretary had arbitrarily and capriciously relied on faulty data, *see id.* § 706(2)(A). In considering the proper remedy, this court wrote:

> The Secretary has asked that we direct the district court to remand to her for further rulemaking should we invalidate this rule. We decline.
>
> Both district courts invalidated the malpractice rule. The effect was to reinstate the prior method of reimbursement. . . . The only proper result is to pay the hospital according to existing regulations.
>
> The hospitals seek reimbursement for the fiscal year 1979-80. Four years is long enough for them to wait.

762 F.2d at 1569 (citations omitted). This court remanded to the PRRB for payment of the hospitals' insurance costs under the pre-1979 reimbursement rule. The Secretary petitioned for reconsideration and rehearing en banc; that petition was denied on January 15, 1986. The plaintiff hospitals in *Lloyd Noland* have received payment under the pre-1979 rules.[8]

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[8] Since the *Lloyd Noland* case, this court has decided one other case involving the malpractice insurance regulations. *Charter Medical Corp. v. Bowen,* 788 F.2d 728 (11th Cir.1986). In that case, the district court ordered the Secretary to pay the plaintiff hospitals under the pre-1979 rule for cost years that had past *and* one cost year that was upcoming; the Secretary only appealed the prospective grant of relief for the upcoming cost year. *Id.* at 730 n. 1. On appeal, this court

C. *Administrative Filings and Appeals*

All thirty-five hospitals involved in this consolidated appeal filed, at the appropriate time, cost reports with their fiscal intermediaries, claiming reimbursement for the cost of services provided to Medicare beneficiaries. Thirty of the hospitals claimed in their cost reports reimbursement for malpractice insurance costs using the pre-1979 rule. These hospitals, in simple terms, ignored the 1979 rule and filled out cost reports as if it did not exist. For these thirty hospitals, their fiscal intermediaries "disallowed" reimbursement under the pre-1979 rule. The fiscal intermediaries issued Notices of Program Reimbursement ("NPRs") reflecting the adjusted total reimbursements. The thirty hospitals each appealed to the PRRB; these appeals were consolidated into the Florida Hospital Association Group Appeal before the PRRB. At the request of the hospitals, the PRRB certified for expedited judicial review the question of the validity of the 1979 rule.

Five other hospitals, however, followed a different path.[9] Instead of ignoring the 1979 rule and claiming reimbursement under the pre-1979 rule, those five hospitals

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rejected the district court's order of prospective relief for a hospital, because the PRRB had not yet issued a final decision for that cost year. The court explicitly based its holding on the concession by the Secretary that the hospitals would later be able to receive relief *after* the PRRB had issued its initial ruling on the as yet undecided cost year. *Id.* at 735. In other words, the district court did not have the power to award relief from a cost determination that had not yet been finalized within the administrative review process.

[9] Three of the hospitals (Santa Rosa Hospital, Jackson County Hospital, and Shands Teaching Hospital and Clinic) were originally plaintiffs in the *Tallahassee Memorial Regional Medical Center v. Heckler* case filed in the Northern District of Florida. Two hospitals (Mercy Hospital and Abbey Hospital and Medical Center) were plaintiffs in *Baptist Hospital of Miami v. Heckler,* filed in the Southern District of Florida. None of the plaintiffs in the *Parkway Medical Center v. Heckler* case, consolidated at the district court level with *Baptist Hospital,* fall into this category of "self-disallowing" hospitals. Mercy Hospital is seeking reimbursement for the 1981 cost year. The

filled out their cost reports using the then current 1979 reimbursement rule; these hospitals, unlike the thirty other hospitals, followed the 1979 rule as promulgated and "*self*-disallowed" the medical malpractice costs.[10] Because they did not file under the pre-1979 rule (in other words, because they filed a "correct" report under the then current regulations), their fiscal intermediaries did not need to adjust their cost reports downward to bring them into conformity with the 1979 rule. Thus, the NPRs for these five hospitals did not reflect any adjustments or denials of claims. After receiving their NPRs, these five hospitals timely appealed to the PRRB, challenging the 1979 rule; their appeals were consolidated into the Florida Group Appeal. When the PRRB certified the question of the validity of the rule for judicial review, however, the PRRB declined to accept jurisdiction over the appeals of the five hospitals that applied the 1979 rule, because the pre-1979 claims "were not claimed on the hospitals' cost reports . . . nor had the NPR included any denials or adjustments of costs related to these issues." Appellant's Brief at 10. Notwithstanding the fact that the cost reports did include all of the information needed to make the pre-1979 calculations, the PRRB stated that "a provider must have made an overt disclosure (notice) of its posture on a particular issue which ordinarily would be evidenced by claiming

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other four self disallowing hospitals are seeking reimbursement for the 1980 cost year. At issue for the five hospitals combined is a total of over $130,000. *See* Appendix B, complaint, *Baptist Hospital.*

[10] The concept, and term, of "self-disallowance" is not found in the Medicare statutes or regulations. It is however, commonly used (at least by the hospitals and in the case law) to describe Medicare providers who applied the 1979 rule in their cost reports, rather than claiming reimbursement under the pre- 1979 rule and therefore forcing their fiscal intermediaries to disallow their claims. For lack of a better term, we will use it to refer to this group of hospitals.

Among other things, self-disallowing hospitals argue that to claim reimbursement under the pre-1979 regulations would have put them in risk of criminal penalties for fraud under the Medicare statutes. *See* 42 U.S.C § 1395nn.

reimbursement for the particular item on the cost report." *Id.* Thus, for the self-disallowing hospitals, the PRRB refused jurisdiction; because of this, the Secretary argues, the federal courts have no jurisdiction over the claims of the five self-disallowing hospitals.

D. ***Litigation in the District Courts***

Because of the venue and timing requirements in the Medicare statute, 42 U.S.C. § 1395oo(f)(1), the thirty-five hospitals could not bring one consolidated case into a single district court. Three suits were filed, *Tallahassee Memorial Regional Medical Center v. Heckler* in the Northern District of Florida, and *Baptist Hospital of Miami v. Heckler* and *Parkway Medical Center v. Heckler* in the Southern District of Florida. The latter two cases were consolidated at the district court level. In both litigations, initiated well before this circuit's decision in *Lloyd Noland,* the Secretary defended the 1979 rule as valid, and also argued that the district courts did not have jurisdiction over the claims of the five self-disallowing hospitals.[11]

In the *Baptist Hospital* case, on September 24, 1984, the district court denied the Secretary's motion to dismiss the self-disallowing hospitals and granted the plaintiffs' motions for summary judgment. In holding that the district court did have jurisdiction over the claims of the self-disallowing hospitals, the district court ruled that the claimed malpractice insurance costs were "contained" in the cost reports, and thus the PRRB (and therefore the

[11] In both litigations, the Secretary also claimed that the 60-day period following agency action within which a Medicare provider could file a suit in district court was a jurisdictional limitation, instead of a simple statute of limitations. Both courts below rejected this argument and, given the facts of the cases, found subject matter jurisdiction. This question was settled by this court in *Lloyd Noland,* which held the period to be a statute of limitations. 762 F.2d at 1564. The Secretary has not attempted to reargue this issue in this appeal.

district court) had jurisdiction. In granting the plaintiffs' motions for summary judgment, the court ruled that the Secretary's basis and purpose statement was inadequate under the Administrative Procedures Act [*sic*], that the 1979 rule was arbitrary and capricious, and that the rule violates the Medicare statute itself. The district court remanded the matter to the Secretary "for further consideration in accordance with [the court's] opinion."

This court issued its *Lloyd Noland* decision on June 12, 1985. On June 20, 1985, in the *Tallahassee Memorial* case, the district court rejected the Secretary's motion to dismiss the claims of the self-disallowing hospitals, relying on the district court opinion in *Baptist Hospital.* The court also struck down the 1979 rule, relying on the binding authority of the *Lloyd Noland* case. In a final judgment entered on August 29, 1985, the court remanded the case to the PRRB "for payment of the plaintiff hospitals' malpractice insurance costs pursuant to the [pre-1979 rule] without reference to the [1979 rule]."

E. *Litigation in this Court*

Following the district court's decision in *Baptist Hospital* case (finalized 11 months before *Tallahassee Memorial*), the Secretary appealed to this court.[12] Prior to

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[12] Soon after the papers in the *Baptist Hospital* case were filed with this court, the court *sua sponte* raised the jurisdictional question of whether the district court's remanding the case to the Secretary for further consideration constituted a final appealable order under 28 U.S.C. § 1291 (1982). The parties submitted memoranda on the question, all arguing that the order was final and thus this court did have jurisdiction. By its order dated July 29, 1985, this court carried the question with the case, to be decided by the oral argument panel.

After reviewing the record in the case, we find that the order was final, and thus appealable. The only appropriate action the Secretary could have taken on remand was to pay the plaintiff hospitals under the pre-1979 malpractice rule. Thus, as far as the district court was concerned, the litigation of the merits was completed. Our findings of jurisdiction is supported by the opinion in *Lloyd Noland,* which involved a similar district court order.

the setting of the briefing schedule, this court issued its opinion in the *Lloyd Noland* case. The Secretary timely filed for reconsideration and rehearing in the *Lloyd Noland* case. The Secretary then filed in the *Baptist Hospital* case a motion to hold the appeal in abeyance pending resolution of the *Lloyd Noland* petition for reconsideration. In the *Baptist Hospital* motion, the Secretary wrote that the appeal "presents the identical issue already decided by the Court in the *Lloyd Noland* case." Appellant's Motion to Hold This Appeal in Abeyance Pending Decision in Another Case at 1. Arguing that judicial economy would be best served, the Secretary summarized the issues in *Baptist Hospital*:

> While [this case] involves a jurisdiction issue not present in *Lloyd Noland,* that issue—which concerns the right to obtain review of the validity of the regulation without raising the issue in cost reports filed with the intermediary—goes only to two hospitals. Thus, whatever the outcome of *Lloyd Noland,* it will be dispositive as to all but two hospitals in the instant appeal, and even the jurisdictional issue will be mooted as to the two hospitals if the Court disposes of the case on rehearing in the Secretary's favor.

Id. at 2. The motion was granted on August 14, 1985.

In the petition for rehearing in the *Lloyd Noland* case, the Secretary informed this court that, five days after the issuance of the *Lloyd Noland* opinion, the Secretary published a notice of proposed rulemaking, proposing a new malpractice insurance regulation that would be retroactive to the date of promulgation of the invalidated 1979 rule. *See* Appellant's Petition for Panel Rehearing, *Lloyd Noland.* The Secretary argued that the new rule, when finalized, would moot the claims of the plaintiffs in *Lloyd Noland.* The Secretary asked the *Lloyd Noland* panel to vacate its order requiring payment under the pre-1979 rule, and to remand the case to the Secretary for further proceedings. *Id.* at 4. The court rejected the request for a

remand and denied the Secretary's petition for rehearing on January 15, 1986. The Secretary did not petition the Supreme Court for a writ of certiorari.

By the time the *Lloyd Noland* rehearing petition was denied (thereby ending the period that *Baptist Hospital* was held in abeyance), the Secretary's appeal of the district court's decision in the *Tallahassee Memorial* case had reached this court. The plaintiffs/appellees in both cases filed motions for summary action in favor of most of the hospitals, based on the *Lloyd Noland* opinion; the motions argued that, except for the self-disallowing hospitals, *Lloyd Noland* completely controlled the disposition of the cases. Without directly stating any opposition to summary action for the *non*-self-disallowing hospitals, the Secretary responded to the motions by stating that summary action was inappropriate for the self-disallowing hospitals, a point the appellees had conceded in their motions. A panel of this court denied the motions for summary action.

At that same time, the Secretary moved to consolidate the appeals in the two cases, *Baptist Hospital* and *Tallahassee Memorial Regional Medical Center.* The Secretary argued that the two cases "involve virtually identical challenges to the same Medicare reimbursement regulation and in both cases the district courts ruled against the Secretary on a jurisdictional issue pertinent only to some of the plaintiffs in each case. Consolidation of the cases will therefore serve the goal of judicial economy." Motion for Appellant for Consolidation of Cases and for New Briefing Schedule at 1-2. That motion was granted on March 4, 1986.

On March 20, 1986, the Secretary filed his initial brief as appellant. The only "Issue Presented" was "[w]hether the two District Courts erred when they held that the Provider Reimbursement Review Board must accept jurisdiction over costs that a Medicare provider failed to claim or

otherwise disclose on its cost report." Appellant's Brief at 2. In the Statement of the Case, the brief included a footnote:

> This Court held the malpractice rule invalid in *Lloyd Noland Hospital and Clinic v. Heckler,* 762 F.2d 1561 (11th Cir.1985), *reh. denied,* No. 84-7444 (January 15, 1986). On June 17, 1985 (50 *Fed.Reg.* 25178), the Secretary published a Notice of Proposed Rulemaking to replace the malpractice rule with a new regulation effective for cost reporting periods beginning on or after July 1, 1979. This Court denied the Secretary's petition for rehearing in which the government contended that the appropriate remedy in *Lloyd Noland* was a remand to the agency for application of the new rule promulgated pursuant to the NPRM. While defendant continues to believe that the Court should refrain from ordering payment under the pre-1979 regulations, he acknowledges that *Lloyd Noland* is controlling as to the validity of the current malpractice rule, in that the new malpractice rule has not yet been published as a final regulation. (*See* Response of Appellant to Appellees' Motion For Summary Action). Defendant incorporates by reference all his arguments in *Lloyd Noland* in these appeals, and he will notify the Court as soon as a new rule is issued.

Id. at 4 n. 1. The hospitals filed their Brief for Appellees on May 1, 1986; that brief responded only to the single "Issue Presented" in the Secretary's initial brief.

Then, in his reply brief filed May 19th, the Secretary informed this court that he had, on April 1, 1986, promulgated a new malpractice insurance reimbursement rule retroactive to 1979. 51 Fed.Reg. 11142 (Apr. 1, 1986).[13]

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[13] The new regulation was originally designated as 42 C.F.R. § 405.457. Since then, the regulation has been redesignated as 42

The new rule applies only to those hospitals that still have "open" cost reports, i.e., generally those hospitals that have appealed the 1979 rule to the PRRB and to the courts and that have not received a "final" judgment from the PRRB or courts. *Id.* at 11149. In other words, the new rule applies to hospitals that are still in litigation over the 1979 rule. All hospitals (such as those in *Lloyd Noland*) that have received final court judgments are not covered by the new rule.

The Secretary, in the reply brief, argues that the new rule makes this entire case moot, and therefore deprives this court of jurisdiction. Bound in with the reply brief was the Secretary's "Suggestion of Mootness and Motion to Vacate the Two District Court Judgments from which these Consolidated Appeals were Taken and to Remand these Cases to the District Courts with Instructions to Dismiss." [14]

C.F.R. § 413.56 in a reorganization of the Medicare regulations unrelated to this litigation.

In *very* simple terms, the 1986 regulation is a combination of the 1979 and the pre-1979 appraches, although more heavily weighted in favor of the 1979 rule. Under the pre-1979 rules, medical malpractice insurance costs were reimbursed according to the percentage of Medicare patient utilization of the medical facility. The 1979 rules reimbursed the cost in proportion to the amount actually recovered by Medicare patients in malpractice claims. The 1986 rule, simply described, reimburses the providers for an administrative component of the insurance costs according to patient utilization (similar to the pre-1979 rules). The administrative component is 8.5% of the total insurance costs. The remaining 91.5% of the malpractice insurance costs are reimbursed using a formula geared to a national ratio of Medicare recovery similar to the 1979 rule.

We will not consider extensively the administrative rulemaking record underlying the 1986 rule, as the validity of that rule is not properly before this court in this case. Nevertheless, the Secretary submitted the Federal Register section in which the new rule was promulgated as an appendix to his reply brief, in support of his motion to dismiss the case as moot. The content of the Federal Register is therefore properly before this court, and will be considered in this opinion.

[14] In another case before this court, *Charter Medical Corp. v. Bowen*, 788 F.2d 728 (11th Cir.1986), decided five days after the new 1986 rule became final, the Secretary raised in his Petition for Panel Rehearing this exact same challenge to the court's jurisdiction,

The Secretary's reply brief prompted a flurry of filings and motions in this court,[15] starting with the appellee

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because (as the Secretary argued) the new regulation made the case moot. On July 8, 1986, the *Charter Medical* panel rejected the Secretary's claim of mootness and lack of jurisdiction, and denied the petition for rehearing with no opinion.

Normally a summary denial of a petition for rehearing would not carry precedential weight. The Secretary's petition for rehearing, however, raised a jurisdictional challenge, and Fed.R.Civ.P. 12(h)(3) does not allow a court to ignore a jurisdictional issue: "Whenever it appears by suggestion of the parties or otherwise that the court lacks jurisdiction of the subject matter, the court *shall* dismiss the action." (emphasis added). *See, e.g., Seatrain Shipbuilding Corp. v. Shell Oil Co.*, 444 U.S. 572, 100 S.Ct. 800, 63 L.Ed.2d 36 (1980) (reaching and rejecting jurisdictional challenge raised in footnote in petition for rehearing); *Goodwin v. United States,* 602 F.2d 107 (6th Cir.1979) (remanding to district court for determination of facts relevant to jurisdictional issue raised in petition for rehearing in the circuit court); *Kelly v. Hartford Accident and Indemnity Co.,* 294 F.2d 400, 409 (5th Cir. 1961) (reaching and rejecting jurisdictional challenge raised in footnote in petition for rehearing); *Goodwin v. United States,* 602 F.2d 107 (6th Cir.1979) (remanding to district court for determination of facts relevant to jurisdictional issue raised in petition for rehearing in the circuit court); *Kelly v. Hartford Accident and Indemnity Co.,* 294 F.2d 400, 409 (5th Cir. 1961) (reaching and rejecting jurisdictional challenge raised in petition for rehearing), *cert. denied,* 368 U.S. 989, 82 S.Ct. 605, 7 L.Ed.2d 526 (1962); *see also North Carolina v. Rice,* 404 U.S. 244, 246, 92 S.Ct. 402, 404, 30 L.Ed.2d 413 (1971) ("the question of mootness is . . . one which a federal court must resolve before it assumes jurisdiction").

In *In re Ghandtchi,* 705 F.2d 1315 (11th Cir. 1983), this court explicitly held that a case must be dismissed if it becomes moot between issuance of the panel opinion and disposition of a petition for rehearing. Thus, we assume that the *Charter Medical* panel reached and rejected the Secretary's jurisdictional challenge. Because we reach the same conclusion, however, we need not resolve the question of whether the *Charter Medical* case binds this panel.

[15] The post-briefing filings by the parties in this case were very helpful, especially the supplemental authorities submitted to keep this court abreast of the progress of these issues in other courts around the country. The complexity of the filing, however, sometimes bordered

hospitals' motion to strike the Secretary's reply brief.[16] Most of the motions were carried with the case for resolution by the oral argument panel.[17] Argument in the case was finally heard on October 8, 1986.

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on the absurd; one of the late filings was entitled "Appellees' Opposition to Appellant's Motion for Leave to File Brief in Reply to Appellees' Opposition to Appellant's Motion to Vacate."

[16] The hospitals argued that the Secretary's reply brief should be struck because it raised an issue not previously raised in the appeal. The Secretary responded that he had in fact preserved the issue in a footnote in his opening brief, quoted on pages 16-17 of this opinion. The Secretary also argued that the question of mootness, which goes to jurisdiction, can be raised at any time. The hospitals' motion to strike the reply brief was carried with the case.

It is well settled that a party cannot argue an issue in its reply brief that was not preserved in its initial brief. *See United States v. Oakley*, 744 F.2d 1553, 1556 (11th Cir.1984). In this case, the single footnote in the Secretary's initial brief did not sufficiently preserve the mootness issue. Thus, insofar as the Secretary's reply brief addressed the mootness question, the Appellees' motion to strike the brief is granted. Questions of jurisdiction, however, can appropriately be raised at any time in the litigation, and thus the struck portion of the reply brief shall be construed and accepted as a memorandum in support of a motion to vacate for lack of jurisdiction. A few of the post-briefing motions and papers could have been avoided had the Secretary simply not submitted his motion under the title "Reply Brief."

[17] Following the promulgation of the new reimbursement rule, two appellee hospitals in this case filed motions for voluntary dismissal of their claims against the Secretary. The hospitals presumably are satisfied with their reimbursement under the new 1986 rule. A panel of this court, on June 27, 1986, carried the motion concerning Tarpon Springs General Hospital with the case. A different panel, on August 15, 1986, granted the motion for dismissal of Doctor's General Hospital. By separate order, the oral argument panel grants the motion to dismiss Tarpon Springs General Hospital. Thus, of the thirty-five original plaintiffs in these consolidated cases, thirty-three remain. Neither of the two dismissed hospitals were in the group of five self-disallowing hospitals.

Of the other motions carried with the case, the Appellees' motion for leave to file appendix with opposition to appellant's motion to vacate is hereby granted. The remaining motions, including the Secretary's motions to vacate and remand with instructions to dismiss,

F. *Disposition of this Case*

Although raised at the end of the briefing in this case, the mootness and jurisdictional questions are nevertheless the threshold issues that we must confront. Prior to that discussion, however, it is necessary to recognize what may be obvious, that the district courts were correct in finding that the 1979 rule was promulgated in violation of the Administrative Procedures Act [*sic*]. The 1986 regulation and the Secretary's arguments notwithstanding, the *Lloyd Noland* case is binding precedent on that question. 762 F.2d at 1567-68.[18]

Because we find that the 1986 regulation does not moot this case and that the hospitals must be paid under the pre-1979 rules, we must then turn in Part III below to the question of the self-disallowing hospitals. Our analysis of the governing statutory language leads us to conclude that the PRRB should have taken jurisdiction over the claims of the five self-disallowing hospitals, and that they therefore should be paid using the pre-1979 methodology required for the rest of the hospitals.

II. THE EFFECT OF THE NEW 1986 REGULATION ON THIS LITIGATION

We first turn to the Secretary's claim of mootness in light of the new regulation promulgated during the pendency of this appeal. As indicated above, the mootness inquiry is a threshold issue that applies to all thirty-five

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are denied by the effect of this opinion. The *Baptist Hospital* appellees filed a cross-notice of appeal but did not argue any issues in support thereof. As a result, the cross-appeal is dismissed.

[18] As discussed below, the Secretary has argued that even this simple reaffirmance of *Lloyd Noland* is moot because of the new 1986 regulations. Because we find that the new regulations do not moot the entire controversy and do not control the relief granted in this case, however, it is still relevant and necessary to reaffirm the invalidity of the 1979 regulations.

hospitals here as appellees. The 1986 regulation also raises thorny questions about the appropriate remedy (if the case is not moot). The district courts awarded payment to the hospitals using the pre-1979 rules, but the Secretary now argues that the hospitals should be paid using the 1986 rule.

The new rule was promulgated on April 1, 1986, with an effective date of May 1, 1986. 51 Fed.Reg. 11142 (Apr. 1, 1986). On May 19, 1986, the Secretary raised in his reply brief the question of mootness, arguing that the litigation was only a challenge to the 1979 rule, which is no longer the controlling regulation. The Secretary stated that the new regulation will "substantially benefit most Medicare providers." Appellant's Reply Brief at 4. This is true, however, only relative to the 1979 regulation; it is incorrect in relation to the pre-1979 rules.

According to the Secretary, the new 1986 rule is a combination of the 1979 rule (invalidated in *Lloyd Noland*) and the pre-1979 rule. *See* Appellant's Reply to Appellees' Opposition to Appellant's Motion to Vacate at 25; 51 Fed.Reg. at 11186; *see also supra* note 13 (explaining, in simple terms, mechanics of new rule). Under the new rule, a hospital with a 25% Medicare Patient utilization rate would receive reimbursement for 8.97% of its medical malpractice costs. This compares to 25% under the pre-1979 rule and, probably, 5.1% under the 1979 rule. Similarly, a hospital with a 50% Medicare utilization rate would receive 22.11% of its malpractice costs, instead of 50% (pre-1979) or probably 5.1% (1979). *See generally* 51 Fed.Reg. at 11189-90 (table of reimbursement percentages under new 1986 rule). We conclude that most, if not all, of the appellee hospitals would receive substantially less under the 1986 rule than under the pre-1979 regulation.[19]

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[19] In his reply brief, the Secretary suggests that it is "entirely possible that some, if not all, of the plaintiffs properly before the Court in these cases will be satisfied with their reimbursement under the new

The new regulation, promulgated in the wake of the consistent rejection of the 1979 rule by courts around the country, seems to be specifically aimed at short-circuiting on-going litigation challenging the Medicare reimbursement. By its own terms, the new regulation is retroactive to the 1979 cost years, *but only* for those hospitals that still have "open" cost reports, i.e., hospitals that appealed their cost reports to the PRRB (and then to the courts) but have yet to receive a "final determination."[20] Because the "reasonable cost" reimbursement scheme has been largely replaced, *see supra* note 3, the 1986 regulation has only limited prospective effect; only a small percentage of *future* Medicare reimbursement will be covered by the new rule. *See* 51 Fed.Reg. at 11186-87. For the affected cost reports, according to the Secretary, the fiscal intermediaries will "automatically calculate" reimbursement using the new rule, with no additional information being gathered from the hospitals. 51 Fed.Reg. at 11149.[21]

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regulation, thus obviating the need for any further litigation of these claims." Appellant's Reply Brief at 4. Since the promulgation of the new rule, two of the plaintiffs before this court have requested that their claims be dismissed, presumably because either the 1986 rule satisfies them or the cost of litigation is greater than the possible gain when compared to the new rule. *See supra* note 17. The thirty-three other plaintiffs, however, have vigorously asserted their continued dissatisfaction with their reimbursement. Thus, it is obvious that the Secretary was wrong in his hope that the plaintiffs would be satisfied. It is equally obvious, as the Secretary acknowledges, that if this court does not address the claims in this case, these hospitals will continue to litigate seeking reimbursement under the pre-1979 rule.

[20] The new rule will also be applied, at the request of the hospital, to a cost report that is still within the period designated for reopening closed cost reports (i.e., three years from the closing of the report). *See* 51 Fed.Reg. at 11149.

[21] The Secretary has explicitly stated, however, that the new rule will *not* apply to hospitals that self-disallowed malpractice costs under the 1979 rule. Appellant's Reply Brief at 3 n.3. In other words, the five self-disallowing hospital in this case would *not* receive the somewhat

The 1986 rule presents some new and difficult questions for this court in this case. For the reasons stated below, we hold that this case is not moot. Because of this holding, we must then decide what the appropriate remedy should be. Without attempting to decide the validity of the 1986 regulation, we hold that it should not be applied to the claims of the litigants in this case, and they should be reimbursed under the pre-1979 regulations.[22]

A. ***Mootness***

This court is among the first to consider fully the mootness implications and retroactive effect of the 1986 regulation. In this case, we join the Sixth Circuit in rejecting the Secretary's mootness suggestion and in denying retroactive effect to the 1986 rule. *See Mason General Hospital v. Secretary of the Department of Health and Human Services,* 809 F.2d 1220 (6th Cir.1987).[23] The only

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higher reimbursement (relative to the 1979 rule) the new rule affords. The Secretary argues that the five hospitals must be reimbursed under the 1979 rule, even though this court has declared that rule void.

[22] At the outset of this discussion, we acknowledge that the questions of mootness and retroactivity are inextricably intertwined. There are two possible approaches to these questions. We could first analyze and answer the question of retroactivity, and then based on a finding of non-retroactivity decide that the case is not moot. Because mootness is a *jurisdictional* question, however, that approach would be somewhat like putting the cart before the horse.

Instead, we consider the mootness question apart from the issue of retroactivity. To do so, we essentially assume *arguendo* that the 1986 regulation is properly retroactive, and then analyze the mootness question using generalized tests for mootness. Our later finding that the retroactive application of the 1986 rule is inappropriate in this case merely bolsters our holding rejecting the Secretary's mootness argument.

[23] The Sixth Circuit did not specifically focus on the mootness question, but instead analyzed the retroactivity issue and, in rejecting retroactivity, implicitly rejected the suggestion of mootness. *See* 809 F.2d at 1223.

other courts to have addressed the questions have responded differently as to the impact of the 1986 rule.[24] None of those courts, however, discussed their analysis in full.

The case or controversy requirement of the Constitution requires that moot cases be dismissed; in a moot case, there is no longer the vitality and interest among the parties that our adversary system of justice requires. As the Supreme Court has made clear, the "burden of demonstrating mootness 'is a heavy one.' " *County of Los Angeles v. Davis,* 440 U.S. 625, 631, 99 S.Ct. 1379, 1383, 59 L.Ed.2d 642 (1979) (quoting *United States v. W.T. Grant Co.,* 345 U.S. 629, 633, 73 S.Ct. 894, 897, 97 L.Ed. 1303 (1953)). In *County of Los Angeles v. Davis,* the Supreme Court articulated a two part test for mootness:

> "Simply stated, a case is moot when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." We recognize that, as a general rule, "voluntary cessation of allegedly illegal conduct does not deprive the tribunal of power to hear and determine the case, i.e., does

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[24] Three district courts have confronted the new rule, and have remanded the question of reimbursement to the Secretary. *See West Anaheim Community Hospital v. Bowen,* ___ F.Supp. ___ No. CV 84-4452 WDK (C.D.Calif. Oct. 29, 1986) (finding hospitals' challenge moot); *St. Paul Hospital v. Bowen,* 644 F.Supp. 99 (N.D.Tex.1986) (finding 1986 rule to be properly retroactive); *St. Louis University Medical Center v. Bowen,* 655 F.Supp. 72 (E.D.Mo.1986) (remanding for application of new rule). In an order having no precedential value under its local rules, the Second Circuit affirmed a district court's rejection of the 1979 rule, but remanded the case to the district court for "consideration of the validity of the 1986 Malpractice Rule and its effect, if any, on the remedy" or pre-1979 payment, as ordered by the district court. *Bethesda Community Hospital v. Bowen,* slip op. at 2 (2d Cir. June 18, 1986) [795 F.2d 1004, (table)]. One district court has rejected the Secretary's mootness argument. *See Miami General Hospital v. Bowen,* 652 F.Supp. 812 (S.D.Fla.1986).

not make the case moot." But jurisdiction, properly acquired, may abate if the case becomes moot because

(1) it can be said with assurance that "there is no reasonable expectation . . ." that the alleged violation will recur, and

(2) interim relief or events have completely and irrevocably eradicated the effects of the alleged violation.

When both conditions are satisfied i .nay be said that the case is moot because neither party has a legally cognizable interest in the final determination of the underlying questions of fact and law.

440 U.S. at 631, 99 S.Ct. at 1383 (citations omitted).

Beyond this mootness test, there are also at least three exceptions to the mootness doctrine. "The first exception concerns a situation where the issues are capable of repetition, yet evading review." *B & B Chemical Co. v. United States Environmental Protection Agency,* 806 F.2d 987, 990 (11th Cir.1986).[25] With this test and exception to it in mind, we must consider the effect of the 1986 regulation on this litigation.[26]

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[25] The other two exceptions to the mootness doctrine, "where an appellant has taken all steps necessary to perfect the appeal and to preserve the status quo before the dispute becomes moot," and "where the trial court's order will have possible collateral legal consequences." *B & B Chemical Co.*, 806 F.2d at 990, are not applicable to our discussion. This case may in fact present an example of the first exception mentioned in this note, but in light of our disposition we need not decide that question.

[26] Beyond this broad mootness discussion, the five self-disallowing hospitals present a separate mootness issue. Even if we were to find that the 1986 rule applies retroactively or otherwise moots the claims of the hospitals in general, the five self-disallowing hospitals would still have non-moot grounds for challenging the action of the PRRB in denying review of their claims.

Although the Secretary has explicitly stated that the 1986 rule will

not apply to the self-disallowing hospitals, Appellant's Reply Brief at 3 n. 3, he still vigorously argues that their claims are moot. *See* Appellant's Reply to Appellees' Opposition to Appellant's Motion to Vacate at 12-13. Essentially, according to the Secretary, the self-disallowing hospitals must accept reimbursement under the 1979 rule, as if they had never challenged it.

Because, according to the Secretary, the 1986 rule does not alter the position of the self-disallowing hospitals, it is clear that "interim relief or events" have *not* "completely and irrevocably eradicated the effects of the alleged violation," *County of Los Angeles,* 440 U.S. at 631, 99 S.Ct. at 1383.

Even if, *arguendo,* we were to accept the Secretary's contention that the 1986 rule moots the primary claims of all of the hospitals in this case, we would still find that the claims of the self-disallowing hospitals are *not* moot. In arguing about the self-disallowing hospitals, the Secretary misconstrues and ignores the distinct nature of their two claims. Their claims are: (1) they challenge, along with the rest of the hospitals, the reimbursement they received during the relevant cost years, and argue that they should receive reimbursement under the pre-1979 rule; and (2) they challenge the decision of the PRRB that it did not have jurisdiction over their claims. While the 1986 rule may, *arguendo,* moot the first claim, it does not at all affect the second claim. The second claim is a challenge to a specific action by the PRRB, and cannot be mooted unless all ramifications of that action are erased. In this case, unlike with the remainder of the hospitals, the five self-disallowing hospitals would *not* get the "benefit" of the 1986 rule. Even if all the hospitals were to lose on their primary goal of pre-1979 rule reimbursement, the five self-disallowing hospitals can still be heard in court about their right to be treated the same as the other hospitals (i.e., their right to 1986 rule reimbursement).

Thus, the 1986 rule has no effect on and is irrelevant to the challenge by the five self-disallowing hospitals to the PRRB's decision that it lacked jurisdiction. We therefore hold that this court has jurisdiction over this claim of the five hospitals, and (in light of our holding in Part III below) that the hospitals must receive reimbursement calculated with the same formula as used for the remaining hospitals in this litigation. In other words, if we find that the pre-1979 rule should govern the cost reports of the remainder of the hospitals, the five hospitals should receive reimbursement under that rule. If, on the other hand, we were to find that the 1986 rule applies, the five self-disallowing hospitals should have their costs calculated using that method, and *not* the invalidated 1979 rule (as the Secretary proposes).

1. *Claims of the Appellee Hospitals*

The Secretary argues that the hospitals were only challenging the 1979 rule, and now that the 1979 rule is no longer the current, controlling rule, the hospitals no longer have any claims in this litigation.[27] The hospitals, however, have from the outset sought a judgment not only invalidating the 1979 rule but also requiring payment under the pre-1979 rules.[28] In his initial brief, the Secretary did not question the hospitals' interest in reimbursement under the pre-1979 rule. The 1986 rule does not eliminate the hospitals' continuing interest in pre-1979 reimbursement. And finally, it is undisputed that for the vast majority of hospitals in this case, the 1986 rule would

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[27] Although subsumed in his argument on mootness, the Secretary also makes a subtle statutory (but non-mootness) challenge to this court's jurisdiction. The Secretary argues that, under 42 U.S.C. § 1395oo, the federal courts have jurisdiction only over issues specifically and explicitly certified by the PRRB. The federal courts cannot, of course, take jurisdiction over an action by a hospital without either a final decision by the PRRB (or the Secretary if he or she modified the decision of the PRRB) or a determination by the PRRB that it lacks authority to decide a question. The plain language of the statute, however, does not include any such limitations on the power of the federal courts to fashion appropriate remedies in cases over which they have proper jurisdiction. Section 1395oo(f)(1) defines the requirements to obtain judicial review, but does not create limitations on such review. In light of Congress' concern for efficient judicial review of challenges to regulations, as seen in the legislative history of § 1395oo, *see infra* at 43-47, we will not read the statute so as to require, in a case such as this, that a hospital litigate for years to challenge a regulation and then need to litigate for years more about a remedy.

[28] The plaintiff hospitals in each of the three complaints filed in the district courts below made clear their claim for pre-1979 rule reimbursement. *See* Complaint at 33, *Tallahassee Memorial Regional Medical Center v. Heckler;* Complaint at 35, *Baptist Hospital of Miami v. Heckler;* Complaint at 15, *Parkway Regional Medical Center v. Heckler.*

not "completely and irrevocably eradicate" the reduction in reimbursement effected by the 1979 rule.[29]

A review of cases dealing with the mootness supports a rejection of the Secretary's mootness arguments. The 1986 rule does in fact provide to most hospitals a higher reimbursement than permitted under the 1979 rule, but it is nevertheless lower than under the pre-1979 rule. A number of Supreme Court and appellate cases reveal how sensitive is the requirement that the intervening event provide complete relief to the plaintiffs in a litigation. In two election cases decided on the same day, for example, the Court found one case moot and rejected mootness in another. In *Hall v. Beals*, 396 U.S. 45, 90 S.Ct. 200, 24 L.Ed.2d 214 (1969), the Court dismissed as moot a case challenging a six-month residency requirement for voting. Prior to decision by the Court, the state legislature changed the requirement to two months; because all of the plaintiffs, at the time of the start of the litigation, would have been able to vote under the new rule, the case was moot.[30] On the other hand, in *Brockington v. Rhodes*, 396 U.S. 41, 90 S.Ct. 206, 24 L.Ed.2d 209 (1969), the Court found that an intervening reduction of a signature requirement (to get on a ballot) from 7% to 4% of registered voters did not moot the case where the plaintiff would not have met the new requirement either.

This case is unlike that in *Richardson v. Wright*, 405 U.S. 208, 92 S.Ct. 788, 31 L.Ed.2d 151 (1972), where the Court remanded the case to the Secretary of Health,

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[29] This discussion does not presuppose a rejection of retroactivity for the 1986 rule; it simply holds that the hospitals have enough of a continuing interest in their claims to get over the mootness hurdle. Although we later reject retroactivity, *see infra* slip opinion at 2601-2606, at ____ __ ____, it would not be inconsistent to reject mootness yet still uphold retroactivity.

[30] Also relevant was the fact that in *Hall* the problem was unlikely to re-occur. The issue of a repeating problem evading review is discussed in the next section.

Education and Welfare. The plaintiffs in that case had had their disability benefits suspended without notice or opportunity to present evidence to defend the benefits. Prior to oral argument, the Secretary adopted a new regulation which provided all of the requested pre-suspension process *except* an opportunity for an oral presentation. While not finding the case to be moot, the Court withheld judicial action pending application of the new regulation. The Court reasoned that the additional process for the individual plaintiffs may provide the claimants with all of the process to which they were entitled, and so the Court could avoid the question of the oral presentation. In *Richardson*, it was possible that on remand the new procedures would fully satisfy the plaintiff's substantive claims. In this case now before this court, however, there is no mystery about what would happen on a remand to the Secretary—the Secretary has made it quite clear that the 1986 rule would be applied and that the hospitals would receive less than under the pre-1979 rule. Because we cannot hope to avoid the difficult legal issues presented in this case, as the Supreme Court did in *Richardson*, the *Richardson* case does not suggest to us a finding of mootness.[31]

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[31] *Relf v. Weinberger*, 565 F.2d 722 (D.C.Cir. 1977), also does not suggest a finding of mootness. In that case, the district court had imposed certain restrictions on the financing of human sterilizations by the Department of Health, Education and Welfare. During the litigation, the Department implemented new regulations that were *more* restrictive than those imposed by the district court. In light of the substantive content of the new regulations, and the fact that one of the two sets of plaintiffs withdrew its cross-appeal, the D.C.Circuit ruled that the case was moot. Unlike the case before this court, the *Relf* court found that the "litigation [was] wanting in the vitality appropriate for resolution . . . of the legal questions presented." *Id.* at 727.

Also distinguishable is the opinion of the District of Columbia Circuit in *Center for Science in the Public Interest v. Regan*, 727 F.2d

In a case analogous to this one, the Sixth Circuit rejected a suggestion of mootness in, concidentally, a Medicare case where the Secretary of Health, Education and Welfare argued that intervening amendments to the Social Security Act fully satisfied the plaintiffs' concerns. *See Himmler v. Califano*, 611 F.2d 137, 149 (6th Cir. 1979). Because the Sixth Circuit found that the amendments only ameliorated but did not eliminate the plaintiffs' concerns, the court rejected the suggestion of mootness. Similarly, the former Fifth Circuit rejected a suggestion of mootness after the Environmental Protection Agency (the defendant-respondent in the case) withdrew its required approval of a state air quality plan. *See Natural Resources Defense Council v. Environmental Protection Agency*, 489 F.2d 390 (5th Cir.1974), *rev'd in part on unrelated grounds sub nom. Train v. Natural Resources Defense Council*, 421 U.S. 60, 95 S.Ct. 1470, 43 L.Ed.2d 731 (1975) (not addressing mootness question on appeal and thus implicitly accepting Fifth Circuit's rejection of mootness challenge to jurisdiction). Although the challenged air quality plan was no longer current, "the EPA's position [was] still considerably at odds with the position taken by the [plaintiffs]." *Id.* at 405. In that case, the facts revealed that the EPA was likely to approve a plan very similar to the challenged plan. Therefore, the Fifth Circuit refused to find the case moot. In this case,

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1161 (D.C.Cir.1984). That case involved an attempt to delay the recision of a regulation that had yet to go into effect. After the first recision was successfully challenged in district court, the D.C. Circuit held that a subsequent recision promulgated during the appeal made the appeal moot. The case now before this court, on the other hand, involves an attempt to retain an already existing regulation that substantially affects the amount of the hospitals' reimbursement. Ultimately, as is clear in our discussion below of the possibility of abusive regulation, Judge Wright's dissent in the *Center for Science* case seems to follow a stronger line of reasoning than is employed by the majority.

the Secretary has *already* adopted a rule similar to the invalidated 1979 rule.

The 1986 rule does not afford the complete relief anticipated by the Supreme Court in *County of Los Angeles v. Davis* in its two prong test for mootness. The parties still have an interest in this litigation sufficient to satisfy the constitutional requirement of a vital case or controversy. In light of these two factors, we hold that the claims of the hospitals have not been mooted by the promulgation by the Secretary of the 1986 regulation.

2. *Claims Evading Review*

In addition to a finding that the 1986 regulation does not eliminate the hospitals' interest in reimbursement under the pre-1979 rules, the second prong of the *County of Los Angeles* mootness test also suggests a rejection of the mootness argument. In this case, it cannot be said with "assurance that 'there is no reasonable expectation . . .' that the alleged violation will recur." 440 U.S. at 631, 99 S.Ct. at 1383. This rule, in conjunction with the exception to the mootness doctrine for cases capable of evading review, supports a finding that this case is not moot.

The facts of this case are unlike most instances where the "evasion" exception is appropriate; usually the exception applies to cases with very short duration. Nevertheless, if this case is dismissed as moot, we would be creating a class of cases capable of evading judicial review by the very fact that, after years of litigation challenging an administrative regulation, an agency would be able to moot a given lawsuit by promulgating a new regulation. If we were to find this case moot, the hospitals would have to restart on a long and expensive litigation only to be confronted again with the possibility that the Secretary could moot that litigation. The Secretary has in fact even acknowledged that such a scenario is conceivable; the

Secretary suggested that this possibility should not be a cause for concern. *See* 51 Fed.Reg. at 11186.

Without at all wishing to suggest any improper motive on the part of the Secretary in this case, and realizing that the Secretary is concerned about the liquidity of the trust fund crucial to the entire Medicare program, it is still a concern that a finding of mootness could permit, in some future case, an abuse of the interaction between administrative agencies and the courts. "Where a court is asked to adjudicate the legality of an agency order, it is not compelled to dismiss the case as moot whenever the order expires or is withdrawn." *Nader v. Volpe*, 475 F.2d 916, 917 (D.C.Cir.1973). In a review of agency action, a sufficiently live controversy may remain in a case even after a regulation or order initially giving rise to the case is no longer in effect. *See Southern Pacific Terminal Co. v. ICC*, 219 U.S. 498, 515, 31 S.Ct. 279, 283, 55 L.Ed. 310 (1911); *Environmental Defense Fund, Inc. v. Gorsuch*, 713 F.2d 802, 810-11 (D.C.Cir.1983); *Big Rivers Electric Corp. v. EPA*, 523 F.2d 16, 19 (6th Cir.1975), *cert. denied*, 425 U.S. 934, 96 S.Ct. 1663, 48 L.Ed.2d 175 (1976).

This case presents two additional concerns that militate against a finding of mootness. First, we would be creating a situation in which an agency, if it were inclined, could avoid review of an agency action and potentially abuse the review process. The ability to moot a case by replacing a challenged regulation with a similar rule after years of litigation could be abused. Second, the ability of an agency to moot a case at will could lead to an enormous waste of judicial resources.[32] Both of these concerns, about

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[32] An example of such abuse, and an expression of concern about it, is found in *Center for Science in the Public Interest v. Regan*, 727 F.2d 1161 (D.C.Cir.1984) (Wright, J., dissenting).

judicial resources and abusive rulemaking, are present in the case now before the court, and lead to the conclusion that the case is not moot.[33]

Our rejection of the Secretary's mootness arguments are further supported by equitable concerns arising from the court's and appellees' reliance on the Secretary's statements early in the litigation in this court. Nine months before the new 1986 rule became final (but well after the Secretary had begun work on it), the Secretary requested that we hold the *Baptist Hospital* appeal (prior to its consolidation with the *Tallahassee Memorial* case) in abeyance pending the disposition of a petition for rehearing in the *Lloyd Noland* case:

> Appellants suggest that judicial economy would best be served by holding the briefing in this appeal in abeyance pending final disposition in *Lloyd Noland*. While one of the instant cases involves a jurisdictional issue not present in *Lloyd Noland*, that issue—[the self-disallowance question]—goes only to two hospitals. Thus, whatever the outcome of *Lloyd Noland, it will be dispositive as to all but two hospitals in the instant appeal*, and even the [self-disallowance] issue will be mooted as to the two

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[33] We note that the Secretary has stated his view that the promulgation of the 1986 rule "does not detract from the powers of the judiciary to consider hospitals' claims for reimbursement in excess of the amounts allowed by this regulation." 51 Fed.Reg. at 11151. Nevertheless, it is clear from the record that the Secretary rushed the new regulation through the rule making process "in order to avoid further losses to hospitals litigating the July 1979 malpractice rule." Memorandum from C.M. Haddow to the Secretary (Jan. 24, 1986) (*reprinted in* Appellees' Response in Opposition to Appellant's Motion to Vacate the Judgments Below, Appendix 5). The potential for abuse is real if agencies are allowed to moot claims by hurried rule making. *See Center for Science in the Public Interest v. Regan*, 727 F.2d 1161, 1171 (D.C.Cir.1984) (Wright, J., dissenting).

hospitals if the Court disposes of the case on rehearing in the Secretary's favor. Accordingly, it seems wasteful to spend time and money at this point in briefing the instant appeal. If the *Lloyd Noland* outcome should leave any outstanding issues for decision, the briefing in this appeal could then be so limited.

Appellant's Motion to Hold This Appeal in Abeyance Pending Decision in Another Case at 2, *Baptist Hospital* (Aug. 14, 1985). But for the court's granting of this motion, the case of many of the appellees here would have been briefed and argued (and probably decided) before the new rule became final. A party cannot request a delay in this court and then later attempt to use that delay to tactical advantage. Had the Secretary suggested, in his motion to hold the litigation in abeyance, that the rights of the opposing parties might be compromised by a delay, this court might have hesitated to grant the delay.[34]

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[34] This case is analogous to *Buccaneer Point Estates v. United States*, 729 F.2d 1297 (11th Cir.1984), in which this court rejected the retroactive application of a new regulation where the private party, acting in good faith, delayed completion of a construction project at the request of the Army Corps of Engineers pending the resolution of the Corps' concerns about the project. After the Corps determined that its concerns were unfounded, the construction was resumed. The Corps then changed a regulation to require additional permits for the construction. In assessing whether the new permits must be obtained, this court wrote that it must "balance the effects of retroactive application against the 'mischief of producing a result which is contrary to statutory design or to legal and equitable principles.' " *Id.* at 1299 (quoting *McDonald v. Watt*, 653 F.2d 1035, 1043 (5th Cir.1981) (citations omitted)). Because the parties had acted in good faith in attempting to cooperate with the Corps, this court rejected the contention that the new regulation should apply retroactively. Similar equitable concerns suggest that the case now before this court should not be dismissed as moot.

B. ***Retroactivity***

Having held that the 1986 regulation does not moot the case and require a dismissal, we are still confronted with the question of whether the hospitals should be reimbursed under the 1986 rule or the pre-1979 rule. As noted above, it would not be inconsistent to reject the suggestion of mootness but still hold that the 1986 regulation should apply. For the reasons discussed below, however, we hold that the hospitals should receive reimbursement under the pre-1979 regulations.[35] In doing so, we join the only other court in the country to address fully the issue of the retroactivity of the 1986 rule. *See Mason General Hospital v. Secretary of the Department of Health and Human Services*, 809 F.2d 1220, 1231 (6th Cir.1987).

At the outset, we note that the Secretary claims to have broad authority to make retroactive regulations under 42 U.S.C. § 1395x(v)(1)(A) (1982).[36] While it is clear

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[35] We note at the outset that this court rejected, in the *Lloyd Noland* case, the Secretary's request (made prior to the 1986 rule making) to remand the malpractice insurance issue to the Secretary for further rule making. 762 F.2d at 1569. Many other courts have rejected similar requests. *See, e.g., Cumberland Medical Center v. Secretary of Health and Human Services*, 781 F.2d 536, 538-39 (6th Cir.1986); *DeSoto General Hospital v. Heckler*, 766 F.2d 182, 186, *modified on rehearing*, 766 F.2d 186, *original opinion reinstated on rehearing of rehearing*, 776 F.2d 115, 116 (5th Cir. 1985); *Bedford County Memorial Hospital v. Health and Human Services*, 769 F.2d 1017, 1024 (4th Cir.1985); *Menorah Medical Center v. Heckler*, 768 F.2d 292, 297 (8th Cir.1985); *Abington Memorial Hospital v. Heckler*, 750 F.2d 242, 244 (3d Cir.1984), *cert. denied*, ___ U.S. ___, 106 S.Ct. 180, 88 L.Ed.2d 149 (1985); *Walter O. Boswell Memorial Hospital v. Heckler*, 628 F.Supp. 1121, 1128 (D.D.C.1985). None of these courts were confronted with a situation in which the proposed rule making was already complete.

[36] The Secretary's regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced

that the Secretary has the power to make corrective adjustments in the reimbursement of individual hospitals and groups of hospitals, we join the Sixth Circuit in finding that the Secretary's power under § 1395x(v)(1)(A) to make retroactive rules is limited. *See Mason General*, 809 F.2d at 1225-27.[37] If the power the Secretary seeks is not

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by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) (1982). That section could be read to be limited to corrective adjustments for individual hospitals in the currently reviewed cost year. Alternatively, the Secretary argues that the section gives him power to make retroactive changes to the "methods of determining costs" covering any number of past years, presumably back to the inception of the Medicare program in 1966.

In this case, the Secretary's argument is undermined by the fact that, in 1985, a bill was introduced in Congress (but never passed) that would have given the Secretary the power to make retroactive rules concerning medical malpractice insurance. *See* S. 1550, 99th Cong., 1st Sess. § 115 (1985); *see also* 131 Cong.Rec. S10800, S10802, S10805 (1985).

[37] After a review of the legislative history of this section, the Sixth Circuit rejected the Secretary's interpretation. *See Mason General*, 809 F.2d at 1225-27. We join the Sixth Circuit in holding that "retroactive rulemaking should be upheld only 'when the public interest in retroactively curing the defect outweighs the harm to private interests resulting from the invalid first instance rulemaking.' " *Id.* at 1226 (quoting *Bedford County Memorial Hospital v. Dep't. of Health and Human Services*, 769 F.2d 1017, 1024 (4th Cir.1985)).

The Secretary advances a variety of cases in his support, including *Springdale Convalescent Center v. Mathews*, 545 F.2d 943 (5th Cir.1977). As the Sixth Circuit points out, however, all of the cited cases involve a regulation aimed at recapturing accelerated depreciation. Because the Medicare providers had an opportunity to avoid the effect of the regulation in question, the regulation was "predominantly prospective in nature." *Mason General*, 809 F.2d at 1226. Beyond the Sixth Circuit, at least one other court has rejected the Secretary's arguments. *See Daughters of Miriam Center for the Aged v. Mathews*, 590 F.2d 1250, 1258 n. 23 (3d Cir.1978). *But see Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir.1973) (accepting retroactive adjustments). In 1974, the District Court for the Southern

limited, then he would have the almost unreviewable ability to change retroactively any of the rules within which the hospitals operate; he would be able to reduce the amount of reimbursement the hospitals are due long after the hospitals actually receive and spend the money.[38] We cannot accept such a broad power, and we therefore will review the Secretary's action in this case using the standard judicial tests of retroactive administrative actions.

Because the 1986 rule is retroactive on its face, there is no need to remand the case to the agency for a determination of whether the rule was intended to be retroactive.[39]

District of Florida rejected the Secretary's argument based on 42 U.S.C. § 1395x(v). *See Mount Sinai Hospital of Greater Miami v. Weinberger,* 376 F.Supp. 1099, 1129 (S.D.Fla.1974), *rev'd on other grounds,* 517 F.2d 329, *modified on rehearing, 552 F.2d 179 (5th Cir.1975), cert. denied,* 425 U.S. 935, 96 S.Ct. 1665, 48 L.Ed.2d 176 (1976). On appeal, the old Fifth Circuit adopted without discussion the district court's analysis of the statute. 517 F.2d at 335. Because of our holding today, we need not decide what precedential value the *Mount Sinai Hospital* opinion holds on this issue.

[38] "Adoption of the construction urged by the Secretary would result in his ability to use unfettered discretion in enacting regulations that give retroactive effect to any or every change that is made in the formulas for determining reimbursable costs." *Mason General,* 809 F.2d at 1225. As the Sixth Circuit points out, the Secretary's broad interpretation of his own powers would give him the ability "to repromulgate successive corrective rules with retroactive application to the date of the initial invalidated rule should subsequent attempts at rulemaking likewise be invalidated." *Id.*

[39] [A] court reviewing an agency decision following an intervening change of policy by the

> agency should remand to permit the agency to decide in the first instance whether giving the change retrospective effect will best effectuate the policies underlying the agency's governing act.

National Labor Relations Board v. Food Store Employees Union, Local 347, 417 U.S. 1, 10 n. 10, 94 S.Ct. 2074, 2080 n. 10, 40 L.Ed.2d 612 (1974). In this case, however, the agency has made the retroactivity of the 1986 regulation clear, and thus a remand to the agency is unnecessary.

In analyzing this retroactivity, we are guided by the Supreme Court's statement that the effects of "retroactivity must be balanced against the mischief of producing a result which is contrary to a statutory design or to legal and equitable principles." *SEC v. Chenery Corp.*, 332 U.S. 194, 203, 67 S.Ct. 1575, 1581, 91 L.Ed. 1995 (1947).[40]

1. *Balancing the Interests*

In making the balance suggested by *SEC v. Chenery*, we must consider the interests of the parties in reimbursement under the 1986 rule versus the pre-1979 rule. On the one hand, the Secretary is in good faith arguing to conserve the resources of the trust fund from which Medicare is funded. On the other hand is the hospitals' interest in receiving reimbursement under the pre-1979 rule (in most cases substantially more than afforded by the 1986 rule), and in bringing this litigation to a close.

The Secretary asserts that the hospitals do not have an interest in avoiding the 1986 rule because it explicitly will not afford lower reimbursement than the 1979 rule. In responding to the asserted interest of the hospital, however,

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[40] "A court ordinarily will apply the law in effect at the time it renders its decision. It may refuse to do so, however, when to apply newly enacted legislation to events preceding the legislation would result in manifest injustice." *Springdale Convalescent Center v. Mathews*, 545 F.2d 943, 956 (5th Cir.1977) (citing *Bradley v. School Board*, 416 U.S. 696, 94 S.Ct. 2006, 40 L.Ed.2d 476 (1974)).

> [W]e note that the administrative agency here has no particular expertise concerning the issue of retroactivity. To the contrary, the extent to which retroactive effect may be given to a promulgation is governed by principles of law that have been developed and refined by the courts, primarily in the context of constitutional adjudication.

Daughters of Miriam Center for the Aged v. Mathews, 590 F.2d 1250, 1259 (3d Cir.1978) (refusing to give Medicare regulation retroactive effect).

the Secretary mischaracterizes the comparison: "[T]he new rule should be compared to the 1979 malpractice rule because the 1979 rule—was in effect during the retroactive period. [The new rule] will replace the 1979 rule—not the [pre-1979 rule], which was eliminated for purposes of malpractice insurance cost apportionment in 1979." 51 Fed.Reg. at 11185. "Retroactive application of this final rule will produce no 'ill effects' because . . . hospitals can only benefit under this rule as compared to the 1979 malpractice rule." *Id.* at 11184. Yet in this circuit, the *Lloyd Noland* opinion voided the 1979 rule, and ordered that those plaintiffs be paid under the pre-1979 rule. 762 F.2d at 1569. The 1979 rule, invalidated by courts across the country and validated by none, has ceased to carry any authoritative weight. The Secretary now suggests that the void rule be used as a baseline to evaluate the hospitals' interest in reimbursement. Such an approach must be rejected; it would permit the Secretary to benefit from the 1979 rulemaking, even though the hospitals successfully attacked the 1979 rule.[41] Thus, the interest of the hospitals is in the difference between the 1986 reimbursement and the pre-1979 reimbursement (which is what the *Lloyd Noland* hospitals received).[42]

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[41] In football, if a team gains ten yards on a play in which it commits a five yard penalty, the ball is typically taken back to the original line of scrimmage and the five yard penalty is counted off from there. Adopting the Secretary's approach would be like taking five yards off from the point where the play ended (and thus allowing the team a net five yard gain on a play in which it committed an infraction).

[42] The Secretary expresses a concern for "inconsistent and unfair reimbursement results among different providers," suggesting that the new rule is necessary to prevent hospitals from receiving "windfalls." 51 Fed.Reg. at 11150. Yet the Secretary's view is based on the idea that the *Lloyd Noland* opinion (and others invalidating the 1979 rule) is wrong, and that providers paid under that opinion received a windfall. The Secretary ignores the fact that the 1986 rule itself creates "inconsistent and unfair reimbursement results among different providers"

In assessing the Secretary's concern about the well-being of the Medicare trust fund, we note that the Secretary has largely limited the retroactive effect of the 1986 rule to hospitals still in litigation. In response to a suggestion that the 1986 rule should apply to *all* Medicare providers, instead of only those on appeal, the Secretary made clear that the asserted benefits of the new 1986 rule did not outweigh his own concern for administrative finality:

> In implementing this final rule, . . . the general importance of ensuring the finality of decisions on reimbursement issues outweighs whatever benefits might be received by providers whose malpractice insurance costs are outside the reopening period. . . . Regardless of whether our finality and reopening rules benefit or disadvantage providers in a specific case, their overall role of providing certainty in the administrative process is important enough to warrant their consistent application.

51 Fed.Reg. at 11187. Although the Secretary asserts that the pre-1979 reimbursement rule gives hospitals too much, his own concern for administrative finality outweighs his concern about any possible excessive reimbursement. Yet in this case, the hospitals also have a legitimate concern in finalizing this litigation and receiving their reimbursement. The amounts in question are over $100,000 per cost year for some hospitals. The interest that is due to the hospitals since the beginning of this litigation has greatly increased the amount owed to the hospitals. As this court stated in *Lloyd Noland,* "[f]our years is long enough for [the hospitals] to wait" for their reimbursement. 762 F.2d at 1569. The litigation has already lasted at least five years.

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by limiting the retroactive effect of the 1986 rule to providers that are still in litigation. As discussed below, the Secretary asserts a power to make retroactive rules, yet he failed to create a retroactive rule that would avoid "inconsistent" results.

If the 1986 rule were given retroactive effect for these appellee hospitals, the hospitals have indicated that they would go through the pointless administrative review process just to return to court to challenge the 1986 rule. The new litigation would likely run three or more years beyond that point. Just as the 1986 rule bowed to the Secretary's concern about administrative finality, so it should bow to the hospitals' need to receive their reimbursement and their interest in bringing this litigation to a close. Balancing the interests of the hospitals and the Secretary, we decline to require that the 1986 rule be followed for these hospitals, and hold that the hospitals should be paid using the pre-1979 rule.

2. *Potential for Abuse*

Our decision to require reimbursement under the pre-1979 rule is supported by concerns similar to those expressed in Section II(A)(3) above. While not intending to question the Secretary's good intentions, we cannot condone a regulation aimed specifically at on-going litigations, where the regulation has the effect of preventing the courts from awarding the full relief sought by the parties and already obtained by other hospitals in similar litigation such as *Lloyd Noland.* To permit such a regulation could effectively insulate the Secretary from review by giving him to power to short circuit a case after years of litigation and require the plaintiff parties to start the entire administrative and judicial review process all over again. As discussed above, the Secretary has acknowledged the possibility that, after a future challenge to the 1986 regulation had partially progressed through the courts, he could promulgate yet another regulation to defuse the challenge to the 1986 rule.[43] Such a power could be used to abuse seriously the litigation process.

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[43] *See* 51 Fed.Reg. at 11186. Furthermore, the Secretary could arguably gain the benefit of a lower interest rate or shorter period of

Our concerns find support in the case law. In a case involving the retroactivity of a Department of Housing and Urban Development ("HUD") circular issued after an eviction proceeding had been initiated, the Supreme Court ruled that the new circular should be applied to the ongoing proceeding. The Court noted, however, that a "far different case would be presented if HUD were a party to the suit arguing that it could repudiate its obligations under the [relevant] contract because the Housing Authority had failed to apply the circular." *Thorpe v. Housing Authority of Durham,* 393 U.S. 268, 279 n. 33, 89 S.Ct. 518, 525 n. 33, 21 L.Ed.2d 474 (1969). *See also International Ladies' Garment Workers' Union v. Donovan,* 733 F.2d 920 (D.C.Cir. 1984) (rejecting Labor Secretary's attempt to avoid judgment of court by promulgation of new "emergency" regulation). While in this case the Secretary has good faith concerns about administrative finality, the fact that this 1986 rule is retroactive only to hospitals whose claims are still being reviewed makes the 1986 rule too similar to a possible abusive regulation. This court cannot condone such potential abuse.

C. *The Narrowness of this Opinion*

Finally, we note the narrowness of our holding on the mootness and retroactivity questions. We limit our holdings to control only the cases of hospitals that already

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interest on an ultimate award. While the relevant statutory language is unclear, allowing the 1986 rule to be used would raise the question of whether, in the litigation challenging that rule, interest should be awarded to a victorious hospital dating from the outset of this litigation or the later challenge. To avoid any such problems, if the 1986 rule were to be used, the federal courts would need to retain jurisdiction over the litigations, to ensure that an award of interest would run from the outset of this litigation.

are in the middle of litigation that began as a challenge to the 1979 rule. We do not express an opinion about the possible cases of hospitals whose claims are still being reviewed by the PRRB and have never reached the federal courts. *See* 51 Fed.Reg. at 11194. We express no opinion about the effect of the 1986 regulation on calculations under the new "Prospective Payment System" that has largely replaced the reimbursement system. *See* 51 Fed.Reg. at 11188. Further, we have not addressed any possible constitutional arguments concerning the due process and equal protection rights of the hospitals that might be affected by the 1986 rule versus those paid under the 1979 rule. *See Mason General Hospital v. Secretary of the Dept. of Health and Human Services,* 809 F.2d 1220, 1231 (6th Cir.1987). Lastly, to make clear, we do not express any opinion as to the prospective validity of the 1986 rule itself. *See id.* That issue will surely arise in litigation soon, but the validity of the rule is not appropriately before this court in this case—just as the 1986 rule cannot appropriately prevent this court from considering any awarding relief in this case.

III. THE SELF-DISALLOWING HOSPITALS

Having decided that the 1986 rule is not properly retroactive in this case, we are left with the question of the five self-disallowing hospitals—the hospitals that followed the 1979 regulation in their cost reports (thereby "disallowing" the desired pre-1979 reimbursement themselves) but later timely appealed to the PRRB for reimbursement under the pre-1979 rule. The Secretary argues that these hospitals "failed to include [the malpractice insurance] claims on their cost reports or otherwise raise an issue with respect to such claims with the intermediary." Appellant's Brief at 14. According to the Secretary, because the hospitals did not force their intermediaries to disallow any claimed reimbursement, the hospitals cannot appeal to the

PRRB. The Secretary focuses on 42 U.S.C. § 1395oo(d), which defines the decision-making power of the PRRB. The Secretary argues that the PRRB "properly declined [to take jurisdiction and] to consider the hospitals' claims since the hospitals had failed to satisfy the statutory prerequisites for a hearing on these claims." *Id.* If the PRRB did not have jurisdiction, the Secretary argues, then neither the district courts nor this court can take jurisdiction over the claims.

In the *Baptist Hospital* case, the district court rejected these arguments, writing that the self-disallowing hospitals

> filed cost reports as required by the Medicare statute regulation, and malpractice insurance costs here at issue were matters "covered by such cost reports" within the meaning of the Medicare statute. Because hospital administrators for these hospitals were reluctant to file claims specifically designating cost amounts alleged to be violative of the statute because counsel believed that to do so might subject them to criminal charges for fraud, does not diminish or in any way dilute the fact that [the self-disallowing hospitals] in fact did file their "cost reports" as required and within those reports was contained the basis for contest and reimbursement for inaccurately or improvidently determined allowances.

Order Denying Motion to Dismiss at 5-6, *Baptist Hospital.* Judge Stafford, in the *Tallahassee Memorial* case, cited the *Baptist Hospital* district court decision.

At the outset we note that this circuit has recently decided a closely related case, *North Broward Hospital District v. Bowen,* 808 F.2d 1405 (11th Cir.1987), which involves the appeals of self-disallowing hospitals to the PRRB. The *North Broward* case held that the PRRB properly rejected the appeal of a hospital district that failed to include certain allowable costs in its cost report. As will be dicsussed below, however, *North Broward* does not con-

trol this case because this case involves a different jurisdictional grant of judicial review, one added by Congress after the cost year involved in the *North Broward* case. Unlike in this case, the hospitals in *North Broward* were not challenging the validity of a Medicare regulation, but were merely attempting to raise with the PRRB claims that they inexplicably failed to raise with their intermediaries. *See id.* at 1407 n. 2. While the *North Broward* case is in line with the leading case in this area, *Athens Community Hospital v. Schweiker,* 743 F.2d 1 (D.C.Cir.1984) (*Athens II*), neither opinion requires a finding that the PRRB correctly rejected the appeals of the five hospitals involved here.

A. ***Standard of Review***

Before attempting to resolve this issue, we must first consider the appropriate scope of this court's review of the Secretary's determination of the jurisdiction of the PRRB. Typically, the "standard of review is narrow and this court will not substitute its judgment for that of the agency." *Lloyd Noland,* 762 F.2d at 1565; *accord Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402, 416, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971). The "interpretation of an agency charged with the administration of a statute is entitled to substantial deference." *Blum v. Bacon,* 457 U.S. 132, 141, 102 S.Ct. 2355, 2361, 72 L.Ed.2d 728 (1982). "Where . . . the agency is interpreting its own structure in a technical and complex area, its interpretation should be sustained if it is reasonable and permissible construction of the statue." *Southern Motor Carriers Rate Conference v. United States,* 773 F.2d 1561, 1567 (11th Cir.1985). "Absent a clear error of judgment, the agency's construction should be upheld." *North Broward,* 808 F.2d at 1408.

In this case, however, we are not reviewing the Secretary's interpretation in a "technical and complex"

area. The question of the self-disallowing hospitals revolves around the admittedly difficult interpretation of a few simple phrases. More importantly, the statute to be interpreted is a jurisdictional statue—a type of statute with which courts are quite familiar. *See St. Luke's Hospital v. Secretary of Health and Human Services,* 810 F.2d 325 (1st Cir.1987) (refusing to defer to Secretary on interpretation of 42 U.S.C. § 1395oo); *Celanese Chemical Company v. United States,* 632 F.2d 568, 572 (5th Cir. Unit A 1980) (refusing to defer to agency on jurisdictional question), *cert. dismissed,* 453 U.S. 950, 102 S.Ct. 27, 69 L.Ed.2d 1033 (1981). While being deferential, we must carefully consider any agency action that potentially has the effect of barring access to the federal courts. This is especially true in light of the clear expression by Congress of its concern for efficient access to judicial review, as discussed below.[44]

B. ***Interpretation of 42 U.S.C. § 1395oo***

In attempting to resolve the question of the self-disallowing hospitals, we must closely scrutinize 42 U.S.C. § 1395oo, the section that establishes and controls the PRRB, and that permits appeals of certain claims to the federal courts. For this case, three subsections of § 1395oo

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[44] The need to carefully consider this jurisdictional question is highlighted by the fact that the PRRB itself has been inconsistent in interpreting its own jurisdiction. On a number of occasions the PRRB has decided questions not raised to the intermediaries. *see. e.g., Ravenswood Hospital Medical Center v. Blue Cross Association/Health Care Service Corp.,* Medicare and Medicaid Guide (CCH) ¶ 31,945, at 9607-08 (PRRB 1982); *St. Joseph Medical Center v. Blue Cross Association/Blue Cross of Southern California,* Medicare and Medicaid Guide (CCH) ¶ 30,925, at 9852 (PRRB 1981); *Unity Hospital v Blue Cross Association/Blue Cross of Northern California,* Medicare and Medicaid Guide (CCH) ¶ 31,097, at 10,407 (PRRB 1981).

are relevant: Subsection (a) sets out prerequisites for appeal to the PRRB, subsection (d) defines the decisional power of the PRRB, and subsection (f) describes the conditions under which a Medicare provider can obtain judicial review of reimbursement claims.[45]

In this case, both the district courts and the parties have focused on the interpretation of subsection (d), which outlines the basis and extent of decisions of the PRRB. Similarly, most of the cases cited by the parties base their decisions on analyses of subsection (d). *See, e.g., Athens Community Hospital v. Schweiker ("Athens II")*, 743 F.2d 1, 4-9 (D.C.Cir.1984).[46] After a review of the legislative history of all of § 1395oo, however, we find that because of the specific circumstances of this case subsection (f) is more relevant to the question of self-disallowing hospitals in this case. Recognizing the novelty of this approach, we think that a review of the history of the PRRB itself will reveal the importance and meaning of subsection (f). The legislative history of that subsection, considered and amended by Congress more than any other part of § 1395oo, indicates the concern of Congress in quick and efficient judicial review of issues like those presented in this litigation.

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[45] All three of these subsections are quoted in relevant part *supra* slip opinion at 2584-2585, at ____ __ ____. The full text of subsection (f), with amendments indicated, is reproduced in Appendix I.

[46] This court's recent opinion in *North Broward Hospital District v. Bowen*, 808 F.2d 1405 (11th Cir.1987), explicitly relies on the *Athens II* opinion. *Id.* at 1408-09. Because both *North Broward* and *Athens II* involved appeals procedurally different from the appeals in this case, a different grant of judicial review applies, and different Congressional concerns guide this court's decision. Neither case addressed the situation now before this court, in which hospitals are utilizing a grant of judicial review that Congress specifically added to facilitate challenges to Medicare regulations.

1. *Legislative History of § 1395oo*[47]

In 1972, Congress identified as a problem in the Medicare statutes the lack of any "specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination." H.R. Rep. No. 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S.Code Cong. & Admin.News 4989, 5095. Congress therefore established the Provider Reimbursement Review Board (the "PRRB") and set out "a specific procedure for settling disputed final determinations applying to the amount of program reimbursement." *Id.* The PRRB was aimed at "assist[ing] providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items." *Id.* Congress added that the new procedure "would not apply to questions of coverage or disputes involving individual beneficiary claims." *Id.*

The resulting provision in the Social Security Amendments of 1972, Pub.L. No. 92-603, § 243, 86 Stat. 1329, 1420 (1972), created what is now 42 U.S.C. § 1395oo. As originally enacted in 1972, the provisions of § 1395oo have gone substantially unchanged, with the exception of subsection (f), controlling judicial review of PRRB actions. The original subsection (f) permitted only limited judicial review, confined to cases where the Secretary, on his or her own motion, reversed or modified a PRRB decision:

> (f) A decision of the [PRRB] shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the [PRRB's] decision, reverses or modifies (adversely to such provider) the [PRRB's] decision. In any case where such a reversal or modification occurs the provider of services may obtain a review of such decision

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[47] The amendments to subsection (f) are charted in Appendix I of this opinion.

> by a civil action commenced within 60 days of the date he is notified of the Secretary's reversal or modification. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

86 Stat. at 1422.

Two years later, Congress amended subsection (f) and expanded the scope of the providers' right to appeal to the federal courts. The amended section, renumbered as (f)(1),[48] permits appeal of *any* decision of the PRRB, whether or not the Secretary modifies the decision. The amendment, which left the third sentence of the original section intact, replaced the first two sentences with language that has not since been amended:

> (f)(1) A decision of the [PRRB] shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the [PRRB's] decision, reverses, affirms, or modifies the [PRRB's] decision. Providers shall have the right to obtain judicial review of any final decision of the [PRRB], or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the [PRRB] or of any reversal, affirmance, or modification by the Secretary is received.

Act of Oct. 26, 1974, Pub.L. No. 93-484, 88 Stat. 1459.

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[48] Subsection (f)(2) and (f)(3), added in 1974, allow for the payment of interest to the provider on any contested amounts awarded by the federal courts.

In 1980, Congress continued its trend toward broad judicial review, and added an entirely new authorization of review. Between the second and third sentences in subsection (f)(1), as amended in 1974, Congress inserted a method to bypass parts of the administrative process when challenging a Medicare regulation:

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the [PRRB] of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the [PRRB] shall require for purposes of rendering such determination). . . [T]he determination shall be considered a final decision and not subject to review by the Secretary.

Omnibus Reconciliation Act of 1980, Pub.L. No. 96-499, § 955, 94 Stat. 2599, 2647-48. As originally introduced, the new authorization of judicial review was included as a new subsection of § 1395oo(f), H.R. 7972, 96th Cong., 2d Sess. § 4 (1980); the enacted version was instead inserted within the existing § 1395oo(f)(1). Both the introduced and enacted versions contained the explicit reference to § 1395oo(a) as a prerequisite to judicial review of legal questions; neither version mentioned other subsections within § 1395oo.

The intent of the amendment was to end pointless administrative litigation:

> Under present law, a provider's dissatisfaction with a particular determination made by its fiscal intermediary on the basis of a regulation issued by the Secretary must first be brought to the [PRRB], even though the [PRRB] may not have the authority to reverse or overrule the regulation. (The [PRRB] has no authority, for example, to rule on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge.) The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. Title VIII addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the [PRRB] determines that it lacks jurisdiction to grant the relief sought.

H.R.Rep. No. 1167, 96th Cong., 2d Sess. 394, *reprinted in* 1980 U.S.Code Cong. & Admin.News 5526, 5757. Congressman Cecil Heftel, a proponent of the legislation, explained the amendment more forcefully:

> Unfortunately, the sound intentions of Congress [in creating the PRRB] never have been effectuated, due primarily to fundamental weaknesses that were built into the statute.
>
> Specifically, under current law providers may not seek judicial review of regulations or policies of [the Department of Health and Human Services ("DHHS")] until after the provider has gone through a long, tortuous process of preparing and filing cost reports; awaiting a decision by the fiscal intermediary; and appealing that decision to the PRRB, which must declare what everybody already knows—

> that the PRRB has no authority under law to decide issues regarding the validity of DHHS policies and regulations. Medicare (and thus all taxpayers) must pay a significant portion of the huge costs of conducting this needless, always fruitless litigation exercise. Our bill would change this situation by allowing the provider to obtain immediate judicial review in such cases—namely, those in which the PRRB has no authority to decide the case.

126 Cong.Rec. 22218 (1980). With the exception of modifications to clarify the time for appeal and to facilitate group appeals, § 1395oo(f) has remained unchanged since the 1980 amendments.[49]

2. *Interpretation of § 1395oo(f)*

As the legislative history reveals, 42 U.S.C. § 1395oo(f) contains two separate and distinct grants of judicial review to Medicare providers. *See* Appendix I of this opinion. The first grant of review, contained in the first two sentences in the subsection, has its roots in the original establishment of the PRRB in the 1972 Medicare amendments. Originally limited to review of reversals by the Secretary of PRRB decisions, the grant of review was expanded in 1974 to include all decisions of the PRRB. By its terms, and in light of the legislative history, this grant of review refers to "*decisions* of the [PRRB]" and is affected by subsection (d), which defines the scope of the decision-making power of the PRRB. This grant of judicial review shall be designated in this opinion as the "1972 grant."

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[49] The Social Security Amendments of 1983, Pub.L. No. 98-21, § 602, 97 Stat. 65, 163, included changes to facilitate and require, in certain circumstances, group appeals. The Deficit Reduction Act of 1984, Pub.L. No. 98-369, § 2351, 98 Stat. 494, 1098, changed parts of 42 U.S.C. § 1395oo to clarify the time period for appeals and requirements for group appeals.

The second grant of judicial review, contained in the third through sixth sentences of subsection (f), was added by the 1980 amendments. The grant of review does *not* involve *decisions* of the PRRB, but rather permits review when the PRRB "determines" that it does not have the authority to make a decision about an issue. This second grant of review, designated the "1980 grant," explicitly incorporates the jurisdictional requirements of subsection (a), but makes no reference to subsection (d) or any other subsection. Furthermore, subsection (d) itself requires that decisions of the PRRB be based on a *hearing* before the PRRB; the 1980 grant of judicial review in subsection (f), however, directly dispenses with the hearing. In light of the language and legislative history of subsection (f), we hold that the 1980 grant of judicial review in that subsection does not concern *decisions* of the PRRB, and thus the provisions of subsection (d) concerning decisions of the PRRB are irrelevant to the 1980 grant of judicial review. To obtain judicial review under the 1980 grant of review, providers need only fulfill the requirements of subsection (a)—the only subsection incorporated into the language of the grant of review. Thus, in cases where the PRRB does not have the authority to decide a question of law or regulation, a provider can obtain judicial review by fulfilling the requirements of subsection (a) and petitioning for a determination under subsection (f) that the PRRB lacks the needed authority.

3. *Analysis of the Relevant Case Law*

None of the cases cited by the Secretary undermine our conclusions. On the other hand, the cases cited by the hospitals that have found jurisdiction in similar cases do not utilize the same analysis as we have in this case. This is because most of the cases did not deal with challenges to regulations under the 1980 grant of judicial review, and none of the cases reviewed the full legislative history of 42 U.S.C. § 1395oo.

a. *Cases Rejecting PRRB (and thus Judicial) Review*

The leading set of cases in this area is *Athens Community Hospital v. Schweiker (Athens I),* 686 F.2d 989 (D.C.Cir.1982), *modified on rehearing Athens Community Hospital v. Schweiker (Athens II),* 743 F.2d 1 (D.C.Cir.1984). In those opinions, the District of Columbia Circuit ruled that the PRRB was correct in refusing to exercise jurisdiction in a case where the providers failed to include certain taxes and stock option costs in their cost reports but four years later attempted to reopen the reports and claim reimbursement for them. The D.C.Circuit reasoned that, because the language of 42 U.S.C. § 1395oo(d) suggests that the PRRB only has the power to review claims that were raised in the cost reports, the PRRB could not consider the hospitals claims (and thus the federal courts could not entertain the suits in question).

Athens I and *II,* however, are not directly instructive on the issue confronting this court. The *Athens* case was based on the 1972 grant of judicial review, not the 1980 grant that is at issue here.[50] In fact, the *Athens* cases involved cost years prior to 1980, and thus the second grant of judicial review, added to 42 U.S.C. § 1395oo(f) in 1980, was not at all before the D.C.Circuit in those opinions. The focus of the *Athens* court was on subsection (d), which is relevant to the 1972 grant of judicial review, but not the 1980 grant. *See, e.g., Athens II,* 743 F.2d at 9. The *Athens* cases simply do not consider the factual situation presented here, where self-disallowing hospitals challenged a regulation. Similarly, this court's opinion in *North Broward* involved an appeal under the 1972 grant of review, and the cost year challenged was 1977, before the

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[50] Furthermore, the *Athens* cases did not involve self-disallowing hospitals, although dicta in *Athens II* seems to reject claims of self-disallowing hospitals (and even though dicta in the *Athens I* opinion seems to *endorse* self-disallowance).

creation by Congress in 1980 of the second grant of judicial review.[51]

A number of other cases that plausibly support the Secretary's position also focus only on the 1972 grant of judicial review. In facts very similar to those in the *Athens* case, the Sixth Circuit upheld the PRRB's refusal to take jurisdiction. *See Saline Community Hospital Association v. Secretary of Health and Human Services,* 744 F.2d 517 (6th Cir.1984) (hospital failed to include claim for return on net-invested-equity capital in 1979 cost report). Three other cases involved a challenge to a provision in the Provider Reimbursement Manual, which is not a regulation promulgated by the Secretary. In those cases, the PRRB took jurisdiction over similar claims of other hospitals, and thus apparently had the authority to decide the issue (unlike with a challenge to a regulation). *See Community Hospital of Roanoke v. Health and Human Services,* 770 F.2d 1257 (4th Cir.1985);[52] *St. Mary of Nazareth Hospital Center v. Schweiker,* 741 F.2d 1447 (D.C.Cir.1984); *University of Michigan Hospitals v. Heckler,* 609 F.Supp. 756 (E.D.Mich.1985).

Only two opinions, recently issued by the Sixth Circuit, are directly analogous to this case. *See Baptist Hospital East v. Secretary of Health and Human Services,* 802 F.2d

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[51] The Athens cases involved claims for reimbursement of various income tax and stock option costs that were not submitted with the hospitals' costs reports due to "inadvertence." *Athens I,* 686 F.2d at 991, 992 n. 1. Similarly, the *North Broward* case involved claims for various tax assessment costs that were not claimed in the hospitals' costs reports. 808 F.2d at 1407. The hospitals offered "no explanation" for the failure to claim the costs. *Id.* at 1407 n. 2.

[52] At least one court, in *Alexandria Hospital v. Heckler,* ___ F.Supp. ___ No. 83-0233-R (E.D.Va. Dec. 19, 1985) applied the Fourth Circuit's opinion in *Community Hosptial of Roanoke* to the exact situation presented by the case now before the court. The district court held that the PRRB *did* have jurisdiction over self-disallowing hospitals, and thus federal review was appropriate. Slip op. at ___.

860 (6th Cir.1986). That case involved a challenge by a self-disallowing hospital to a regulation regarding free health care to non-Medicare patients. The *Baptist Hospital East* court essentially required the hospitals to meet the terms of 42 U.S.C. § 1395oo(d), even though a regulation was being challenged under the 1980 grant of review under § 1395oo(f). *See Bethesda Hospital v. Secretary of Health and Human Services,* 810 F.2d 558, 562 (6th Cir.1987) (bound by but suggesting disagreement with *Baptist Hospital East). Baptist Hospital East,* which conflicts with our holding in this case, relies heavily on *Athens II* and *Saline,* neither of which involved the 1980 grant of judicial review. Because the *Baptist Hospital East* opinion did not address the differences between the two grants of review, and did not analyze the legislative history of the relevant provisions, we decline to follow its reasoning.[53]

b. *Cases Finding PRRB (and thus Judicial) Review*

At least two circuit courts, and a number of district courts, have rejected the holdings of the cases discussed above. The courts have not, however, utilized the same analysis as we have here. Again, this is because most (but not all) were faced with appeals arising out of the 1972 grant of judicial review. Most of these courts based their holdings on a broad interpretation of § 1395oo(d), finding that the PRRB was not limited in its review to items

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[53] Even if the *Baptist Hospital East* opinion were for some reason binding on this court, we would still distinguish it from the case now before the court. In interpreting *Athens II,* the *Baptist Hospital East* court wrote "a provider is able to appeal to the [PRRB] when it self-disallowed a cost *but also* timely indicated its disagreement with and challenge to the regulations or rulings compelling the self-disallowance." 802 F.2d at 865-66 (emphasis added). Here, where over 6000 hospitals (including the plaintiffs here) challenged the malpractice insurance regulation in *Hadley Memorial Hospital v. Schweiker,* 689 F.2d 905 (10th Cir. 1982), it is safe to say that the hospitals "timely indicated [their] disagreement" with the regulation.

raised in the cost reports. Those cases that involve the 1972 grant of review have been rejected by this court in *North Broward.*

In *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services,* 689 F.2d 1337 (7th Cir.), *cert. denied,* 464 U.S. 830, 104 S.Ct. 107, 78 L.Ed.2d 110 (1983), the Seventh Circuit confronted the same jurisdictional issues as did the D.C.Circuit in *Athens II,* but reached the opposite result. On the issue of self-disallowance, the Seventh Circuit explicitly held that the PRRB could consider matters not raised to the intermediary. The *St. Mary of Nazareth Hospital Center* opinion involved the 1972, not 1980, grant of judicial review. Similarly, the First Circuit recently rejected the reasoning of the *Athens II* case, in a case involving the 1972 grant of review. *See St. Luke's Hospital v. Secretary of Health and Human Services,* 810 F.2d 325 (1st Cir.1987); *see also Adams House Health Care v. Heckler,* 604 F.Supp. 110 (N.D.Calif.1984); *Our Lady of Lourdes Memorial Hospital v. Schweiker,* 1982 Medicare & Medicaid Guide (CCH) ¶ 32,154, at 10,561 (N.D.N.Y. July 26, 1982); *Memorial Hospital v. Schweiker,* 1981 Medicare & Medicaid Guide (CCH) ¶ 31,603, at 9917 (M.D.Fla. Oct 20, 1981).

Other than the Sixth Circuit cases discussed above, we have located one case addressing the self-disallowance question in the context of the 1980 grant of judicial review; the case involved the same malpractice insurance regulation at issue here, and is nearly identical to this case. *See Alexandria Hospital v. Heckler,* ____ F.Supp. ____ No. 83-0233-R (E.D.Va. Dec. 19, 1985), *on remand from Bedford County Memorial Hospital v. Health and Human Services,* 769 F.2d 1017 (4th Cir.1985), *aff'g Alexandria Hospital v. Heckler,* 586 F.Supp. 581 (E.D.Va.1984). The court ruled in favor of the hospitals and found federal jurisdiction, although not on the same grounds as we find jurisdiction. Like the courts considering appeals arising under the first grant of judicial review, *Alexandria*

Hospital focused on 42 U.S.C. § 1395oo(d), without considering the legislative history of § 1395oo.

4. *Conclusion*

The clear language of the statute and the legislative history of the PRRB lead us to conclude that a self-disallowing provider need fulfill only 42 U.S.C. § 1395oo(a) in order to be able to appeal to the federal courts under the 1980 grant of judicial review in § 1395oo(f). By the terms of subsection (f), a self-disallowing hospital that meets the conditions of subsection (a) can request the PRRB to determine whether it has the authority over a challenge to a regulation. If the PRRB does not have the authority to grant relief to the provider, the provider can appeal to the federal courts.[54]

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[54] Our finding that the PRRB had jurisdiction over the claims of the self-disallowing hospitals (and thus our finding that this court has jurisdiction), is strongly supported by the recent unanimous Supreme Court opinion in *Bowen v. Michigan Academy of Family Physicians*, ___ U.S. ___, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986). In that case, the Court considered a challenge by physicians of a regulation, promulgated under Part B of the Medicare program, which authorizes payment of benefits in different amounts for similar physicians' services. The Secretary contended that Congress had forbidden judicial review of all questions affecting the amount of benefits under Part B of Medicare. The Court rejected this contention and held that jurisdiction existed.

While the *Michigan Academy* case does not directly control this case, the Court's analysis of the jurisdictional question is very instructive. The Court began "with the strong presumption that Congress intends judicial review of administrative action." *Id,* at ___, 106 S.Ct. at 2135. The Court then analyzed the administrative review scheme within Part B of Medicare, and concluded that it focused on the *amount* of reimbursement, not on the broader policy decisions inherent in the regulations. "Unlike the *determinations* of amounts of benefits, the *method* by which such amounts are determined ordinarily affects vast sums of money and thus differs qualitatively from the quite minor matters' review of which Congress [limited]." *Id.* at ___ n. 11, 106 S.Ct. at 2141 n. 11 (emphasis in original). In other words, according to the Court, Congress intended to restrict litigation over

benefits where the underlying regulatory scheme is clear, but did not foreclose judicial review of the regulations themselves.

Directly relevant to this case, at least one court has extended the *Michigan Academy* reasoning to ease the limitations on judicial review for Part A hospitals found in 42 U.S.C. § 1359oo. *See Westlake Community Hospital v. Bowen,* No. C2400 (N.D.Ill. Oct. 3, 1986). [Available on WESTLAW, DCTU database]. Because this possible extension of *Michigan Academy,* which came down after the briefs were submitted in this case, has not been fully considered by the parties or the courts below, we explicitly decline to extend its reasoning at this time. We simply note that *Michigan Academy* strongly supports our holding that the self-disallowing hospitals are properly before this court.

A 1983 Eleventh Circuit Medicare case also strongly supports our holding on this issue, and supports the reasoning behind the *Michigan Academy* case. *See Memorial Hospital v. Heckler,* 706 F.2d 1130 (11th Cir.1983), *cert. denied,* 465 U.S. 1023, 104 S.Ct. 1275, 79 L.Ed.2d 680 (1984). Although not directly relevant to the issue in this case, *Memorial Hospital* dealt with an exception to the grant of judicial review found in 42 U.S.C. § 1395oo(f). Section 1395oo(g) exempts from § 1395oo(f) review of certain health care cost items not covered by Medicare, as detailed in 42 U.S.C. § 1395y. The *Memorial Hospital* court rejected an assertion by the Secretary that § 1395oo(g) prevented judicial review of regulations interpreting § 1395y. The court held that § 1395oo(g) only prevented review of individual determinations under § 1395y by the fiscal intermediaries.

> In essence, the issue here does not involve just an intermediary finding that no payment may be made. Rather, it concerns the validity of the regulation itself. The intermediary merely followed the Secretary's regulation. We hold that section 1395oo(g) does not preclude judicial review of the Secretary's regulation defining patient telephones as "personal comfort items." Section 1395oo(g) does not preclude judicial review of the Secretary's regulations. . . . To expand the non-reviewability of intermediary decision to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review.

706 F.2d at 1133 (citations omitted).

This conclusion is supported by considerating the alternative. Were we to hold that the PRRB (and therefore the federal courts) could not hear the self-disallowing hospitals' challenge to the 1979 rule, we would be ordering the Secretary to reimburse those hospitals under a rule that this court has declared null and void in the *Lloyd Noland* case. The *Lloyd Noland* court ruled that the 1979 rule was arbitrary and capricious under the Administrative Procedures Act [*sic*]. Although *Lloyd Noland* did not reach the question, every circuit court to consider the underlying legal validity of the 1979 rule has found that the rule violates the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A), and thus is illegal as well as being arbitrary and capricious. *See Cumberland Medical Center v. Secretary of Health and Human Services,* 781 F.2d 536, 538 (6th Cir.1986); *Bedford County Memorial Hospital v. Health and Human Services,* 769 F.2d 1017, 1023 (4th Cir. 1985); *Menorah Medical Center v. Heckler,* 768 F.2d 292, 296 (8th Cir.1985); *St. James Hospital v. Heckler,* 760 F.2d 1460, 1470-72 (7th Cir.), *cert. denied,* ____ U.S. ____, 106 S.Ct. 229, 88 L.Ed.2d 228 (1985); *Abington Memorial Hospital v. Heckler,* 750 F.2d 242, 243 (3d Cir.1984), *cert. denied,* ____ U.S. ____, 106 S.Ct. 180, 88 L.Ed.2d 149 (1985). This unanimous rejection of the 1979 rule strongly countenances against using the void rule to calculate the reimbursement of the five self-disallowing hospitals.

In this case, because there is no dispute that the five self-disallowing hospitals met the requirements of § 1395oo(a) (or § 1395oo(b) dealing with group appeals), we hold that the PRRB should have included those hospitals in its determination that it lacks the authority to decide the challenge to the medical malpractice insurance rule. Therefore these five hospitals are appropriately before the federal courts. We thus affirm the district court's denials of the Secretary's motions to dismiss the claims of the self-disallowing hospitals.

IV. CONCLUSION

For the reasons stated in this opinion, we affirm the district courts below and remand these cases for entry of judgments using the pre-1979 rule and including appropriate interest as permitted by statute.

AFFIRMED and REMANDED.

APPENDIX I

Section 1395oo(f)(1) of 42 U.S.C. is reproduced below, with the amendments indicated. Underlining shows the effect (although not the exact changes) of the 1974 amendments, which allowed appeals of PRRB decisions as well as those of the Secretary. Act of Oct. 26, 1974, Pub.L. No. 93-484, 88 Stat. 1459. **Boldface** shows the provisions added in 1980 creating a second grant of judicial review to challenge regulations. Omnibus Reconciliation Act of 1980, Pub.L. No. 96-499, section 955, 94 Stat. 1569, 2647-48. *Italics* shows the 1983 amendments involving group appeals. Social Security Amendments of 1983, Pub.L. No. 98-21, section 602, 97 Stat. 65, 163. ALL CAPITALS shows the 1984 amendments, which clarified the requirements of group appeals and the time to appeal under the 1980 grant of judicial review. Deficit Reduction Act of 1984, Pub.L. No. 98-369, section 2351, 98 Stat. 494, 1098:

> (f) Finality of decision; judicial review; determination of Board authority; jurisdiction; venue; interest on amount in controversy
>
> (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any

reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary is received. **Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which NOTIFICATION OF SUCH DETERMINATION IS RECEIVED. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing.** Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (*or, in an action brought jointly by several providers, the judicial district in which the greatest*

number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. *Any appeal to the Board or action for judicial review by providers which are under common ownership or control OR WHICH HAVE OBTAINED A HEARING UNDER SUBSECTION (B) OF THIS SECTION must be brought by such providers as a group with respect to any matter involving an issue common to such providers.*

EDMONDSON, Circuit Judge, concurring in part and dissenting in part:

In concur in the judgment of the court except with respect to the "self-disallowing" hospitals which, I believe, are unentitled to judicial review.

Congress has painstakingly amended 42 U.S.C. 1395oo(f) through the years. Although the overall effect of these amendments has been to liberalize judicial review of administrative decisions regarding Medicare provider reimbursement, this court is not free to disregard the express limitations which Congress has placed on such review.

Subsection (f) of section 1359oo permits a Medicare provider to obtain expedited judicial review of a challenge to a regulation. It provides in pertinent part that: "Providers shall . . . have the right to obtain judicial review of any *action of the fiscal intermediary* which involves a question of law or regulations relevant to the matters in controversy. . . ." (emphasis added). Under the plain language of subsection (f), expedited judicial review is limited to review of an "action" by the fiscal intermediary.[1]

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[1] Because the language of section 1395oo(f) is a clear expression of Congressional intent, we need not resort to legislative history. *See*

The five "self-disallowing" hospitals in this case never requested their fiscal intermediary for reimbursement under the pre-1979 malpractice rule. Instead, they requested the lesser reimbursement available under the 1979 rule. Accordingly, pre-1979 rule reimbursement was never in controversy; and the fiscal intermediary took no action with respect to the "self-disallowing" hospitals' claims (now advanced to this court) for excess reimbursement available under the pre-1979 rule.[2] In the absence of such action by the fiscal intermediary, federal courts lack jurisdiction to review the self-disallowing hospitals' claims.

United States v. Rojas-Contreras, 474 U.S. 231, 106 S.Ct. 555, 557, 88 L.Ed.2d 537 (1985). The legislative history seems wholly consistent with my reading, however. The history shows that Congress expedited the review process by cutting back on the second (PRRB) stage not by minimizing the first (fiscal intermediary) stage. Had Congress intended to allow parties judicial review in the absence of fiscal intermediary action, Congress could and would have so provided.

[2] Quite simply, the self-disallowing hospitals failed to avail themselves of the avenue of review Congress created for Medicare providers by section 1395oo(f). In their cost reports submitted to the fiscal intermediary, they *could* have requested reimbursement for malpractice costs under the pre-1979 rule. The fiscal intermediary would then have issued notices of program reimbursement denying their claims for excess reimbursement under the pre-1979 rule and granting only the lesser reimbursement available under the 1979 rule. Indeed, the thirty other hospitals in this appeal did precisely that and are entitled to judicial review of their claims.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO: 83-1700-Civ-ARONOVITZ

PARKWAY MEDICAL CENTER; PALM BEACH GARDENS COMMUNITY HOSPITAL; CLEARWATER COMMUNITY HOSPITAL; AND AMISUB OF FLORIDA, PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF THE DEPT. OF HEALTH & HUMAN SERVICES; AND CAROLYNE K. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEFENDANTS

CASE NO: 83-1005-Civ-ARONOVITZ

BAPTIST HOSPITAL OF MIAMI; ABBEY HOSPITAL AND MEDICAL CENTER; BASCOM PALMER EYE INSTITUTE; BETHESDA MEMORIAL HOSPITAL; BOCA RATON COMMUNITY HOSPITAL; BROWARD GENERAL MEDICAL CENTER; CEDARS MEDICAL CENTER; DOCTORS GENERAL HOSPITAL; DOCTORS HOSPITAL OF LAKE WORTH; FLORIDA KEYS MEMORIAL HOSPITAL; FLORIDA MEDICAL CENTER; HIGHLANDS GENERAL HOSPITAL; HOLY CROSS HOSPITAL, INC.; IMPERIAL POINT MEDICAL CENTER; JACKSON MEMORIAL HOSPITAL; JAMES ARCHER SMITH HOSPITAL; LARKIN GENERAL HOSPITAL; LOS OLAS GENERAL HOSPITAL; MARTIN MEMORIAL HOSPITAL; MERCY HOSPITAL, INC.; NORTH BROWARD HOSPITAL; PALM BEACH-MARTIN COUNTY MEDICAL CENTER; PEMBROKE PINES GENERAL HOSPITAL; WALKER MEMORIAL HOSPITAL, PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

MEMORANDUM OPINION AND ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANTS' CROSS-MOTIONS FOR SUMMARY JUDGMENT

Plaintiffs are Part A providers of services under the Medicare program, 42 U.S.C. § 1395x(u). They seek declaratory and injunctive relief holding Administrative Regulation 42 C.F.R. § 405.452(b)(1)(ii) invalid. This regulation alters the computation formula which had been in effect since the inception of the Medicare Program in 1966 and under which provider hospitals were reimbursed for the costs of malpractice insurance.

Plaintiffs' and defendants' cross-motions for summary judgment are before the Court and defendants' motion to strike certain affidavits filed by plaintiffs as an attachment to the Complaint. The parties hereto agree that there is no material issue of fact in dispute and that these actions are ripe for summary judgment.

This Court has carefully reviewed the entire record herein, all memoranda of law, has heard oral argument by respective counsel, and being otherwise fully advised in the premises and for the reasons hereinafter stated, plaintiff's motions for summary judgment are GRANTED, each respectively, defendants' motions for summary judgment are DENIED, each respectively, and the matter is REMANDED to the Secretary for further consideration in accord with this Opinion. The Court further GRANTS defendants' motion to strike affidavits and has not considered such affidavits within the scope of the ruling herein made.

BACKGROUND

At the outset of the Medicare program, the Secretary developed a formula based on utilization principles to determine Medicare's share of hospitals' overhead costs.

42 C.F.R. § 405, Subpart D (1966). This method of calculating reimbursement was also used by private insurance carriers which used "cost-based" reimbursement (*e.g.*, Blue Cross carriers). Under this method, all overhead expenses incurred by a hospital over the course of the year, including all types of standard insurance carried by that hospital, were lumped together in what was commonly referred to as the pool of "general and administrative costs" (hereinafter referred to as the "G & A" costs). The hospital then allocated these G & A costs to all of the revenue producing cost centers of the hospital (*e.g.*, the operating room or the emergency room). Then, Medicare's portion of the total costs was determined on the basis of the utilization by Medicare reimbursed total G & A costs in the same proportion as the number of Medicare patient days bore to the hospital's total patient days. For example, if Medicare patients constituted 80 percent of the patient days at hospital A, and non-Medicare patients constituted the remaining 20 percent, then Medicare would reimburse hospital A for 80 percent of its total G & A costs.

In or about 1979, the Secretary took the position that because the dollar amount of the risk of claims payable to Medicare patients was less than that for non-Medicare patients, the share of a hospital's total malpractice insurance premium properly allocable to the Medicare program was significantly less than the amount calculated under the utilization method; *i.e.*, less than the amount calculated simply using the precentage of a hospital's patient days attributable to Medicare patients. 44 *Fed. Reg.* at 15745.

The new regulation, 42 C.F.R. § 405.452(b)(1)(ii), was published at 44 *Fed. Reg.* 31641 and became effective on July 1, 1979. After that date, hospitals were required to report their actual loss experience from medical malpractice over a five-year period. Medicare would reimburse the hospital that portion of its malpractice insurance premium

that was proportionate to its actual loss experience. Under the former system, Medicare had reimbursed the hospital based upon the average utilization of the hospital services by Medicare beneficiaries.

The Secretary submits that her decision to change the system is fully supported by the Medicare Act which permits the Secretary to use averaging methods for estimating the costs to be paid and which permits her to use different methods in different circumstances. 42 U.S.C. § 1395x(v)(1)(A).

With the exception of Mercy Hospital and Abbey Hospital & Medical Center, plaintiffs explicitly sought administrative review before the Provider Reimbursement Review Board (hereinafter referred to as "PRRB") pursuant to 42 U.S.C. § 1395oo(a). The PRRB decided that it lacked authority to determine whether the Medicare regulation governing reimbursement for malpractice insurance 405.452(b)(1)(ii) is invalid, further found that the case falls within 42 U.S.C. § 1395oo(f)(1), and granted the providers' requests for an expedited judicial review of the malpractice insurance issue (except Mercy Hospital and Abbey Hospital & Medical Center which were not so certified and which are the subject of treatment in a separate ruling on a motion to dismiss issued under even date herewith, wherein the motion to dismiss is denied). This case is before the Court pursuant to 42 U.S.C. § 1395oo. Because of the denial of the motion to dismiss, this ruling applies to all plaintiffs in both consolidated actions.

Plaintiffs attack the subject Medicare regulation both procedurally and substantively. In terms of the procedural grounds, plaintiffs assert:

> A. That the Agency failed to comply with the Administrative Procedure Act (hereinafter referred to as "APA") 5 U.S.C. § 553, in that it failed to issue sufficient notice of the rulemaking; and,

B. That the Agency failed to provide an adequate basis and purpose statement with the malpractice regulation (5 U.S.C. § 553).

The substantive attack upon the subject regulation charges that:

A. It violates (APA) 5 U.S.C. § 706(a)(a) which requires a reviewing court to hold unlawful and set aside agency action found to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law; and,

B. The subject regulation is violative of the Medicare statute because this cost regulation is not rational, it is arbitrary, that it does not further the purposes of the Medicare statute, and fails to allocate costs as required by that law.

This Court is aware that the standard of review of an agency decision is a narrow one. *Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 91 S.Ct. 814, 28 L.Ed.2d 136. However, this does not preclude judicial review and the courts are not required to stand aside and rubber stamp their affirmance of administrative decisions that are deemed inconsistent with a statutory mandate or that frustrate congressional policy underlying a statute. *National Labor Relations Board* v. *Brown*, 380 U.S. 278, 85 S.Ct. 980. *See* also, *Motor Vehicles Manufacturers Ass'n. of the United States v. State Farm Mutual Automobile Insurance Co.*, ____ U.S. ____, 103 S.Ct 2856, 77 L.Ed.2d 443.

Therefore, this Court has proceeded to consider the contentions asserted by plaintiffs in these cases, and the Court has jurisdiction to entertain same.

Status

At least eleven United States District Courts have held the subject regulation to be invalid. *See DeSoto General*

Hospital v. Heckler, Civil Action No. 83-1050-B (M.D. La. June 20, 1984); and, *Metropolitan Hospital, Inc. v. Heckler,* Civil Action No. C-83-502-A (N.D. Ga. June 25, 1984); *Mt. Carmel Mercy Hospital v. Heckler,* no. 82-74193, slip op. (E.D. Mich. Nov. 30, 1983) (DeMascio, J.) *appeal docketed* no. 84-1188 (Mar. 21, 1984); *Abington Memorial Hospital v. Heckler,* No. 82-2856, slip op. (E.D. Pa. Dec. 8, 1983) (Fullman, J.), *appeal docketed* no. 84-1079 (Feb. 15, 1984); *Chelsea Community Hospital v. Heckler,* no. 83CV-6126-AA, slip op. (E.D. Mich. Dec. 29, 1983) (Joiner, J.) (adopting opinion of DeMascio, J. in *Mt. Carmel Mercy Hospital v. Heckler*), *appeal docketed* no. 84-1146 (6th Cir. Mar. 6, 1984); *St. James Hospital v Heckler,* no 83G-2773, slip op. (N.D. Ill. Jan. 26, 1984) (Will, J.) *appeal docketed* no. 84-1478 (7th Cir. March 27, 1984); *Lloyd Noland Hospital and Clinic v. Heckler,* no. CV83-PT-0868-S, slip op. (N.D. Ala. April 6, 1984) (Propst, J.); *Bedford County Memorial Hospital v. Heckler,* no. 83-0386-A slip op. (W.D. Va. March 28, 1984) (Turk, J.); *Albany General Hospital v. Heckler,* No. 83-851-FT, slip op. (D. Oregon March 2, 1984) (Frye, J.) *appeal docketed,* no. 84-3865 (9th Cir. June 6, 1984); *Humana of Illinois, Inc. v. Heckler,* no. 83-3061, slip op. (C.D. Ill. March 2, 1984) (Alderman, J.) (adopting opinion of Will, J. in *St. James Hospital v. Heckler) appeal docketed* no. 894-1727 (7th Cir. April 30, 1984); *St. Joseph's Hospital, Tucson v. Heckler,* no. 82-781, slip op. (D. Ariz. April 24, 1984) (Marquez, J.); *Alexandria Hospital v. Heckler,* no. 83-0233-R (E.D. Va. May 7, 1984) (Merhige, J.).

At least four District Courts have held that the malpractice rule is valid. *See Athens Community Hospital v. Heckler,* 565 F.Supp. 695 (E.D. Tenn. 1983), *appeal docketed,* no. 83-5546 (6th Cir. Aug. 5, 1983); *Cumberland Medical Center v Heckler,* no. 82-2121, slip op. (M.D. Tenn. June 22, 1983) (Morton, J.) (adopting

opinion in *Athens Community Hospital v. Heckler) appeal docketed,* no. 83-5549 (6th Cir. Aug. 9, 1983); *Humana of Aurora, Inc. v. Heckler,* No. 83-2-70, slip. op. (D. Colo. Sept. 19, 1983) (Weinshienk, J.); *appeal docketed,* no. 83-2417 (10th Cir. Nov. 4, 1983); *Walter O. Boswell Memorial Hospital v. Heckler,* 573 F. Supp. 884 (D.D.C. 1983); *appeal docketed,* no. 83-2223 (D.C. Cir. Dec. 2, 1983), (argued June 4, 1984).

No United States Circuit Court of Appeals had yet ruled on the matter, to this Court's knowledge although several appeals are pending.

This Court agrees with the majority of other Courts which have addressed this problem and which have held that the malpractice rule is invalid. This Court therefore now holds the subject regulation to be invalid. Rather than re-state a subject matter which has been thoroughly memorialized by other District Courts, the Court specifically adopts the reasoning and the holding of the opinion of Senior United States District Judge Hubert L. Will in *St. James Hospital v. Heckler,* 579 F.Supp. 1984 (N.D. Ill.), and the opinions of sister Courts not inconsistent therewith, particularly *Abington Memorial Hospital v. Heckler, supra.*

Conclusion

Thereupon in accordance with *St. James Hospital, supra,* this Court hereby *holds* with regard to the procedural grounds as follows:

A. The Court agrees with the reasoning and holding in *St. James Hospital, supra,* and the other Courts so holding that the notice was sufficient to fairly apprise the interested parties; and

B. That the Agency failed to meet the standard proscribed by statute and articulated by the courts requiring an adequate basis and purpose statement with the malpractice regulation and likewise failed to respond

adequately to the uniformly negative public comments on the proposed regulation. The Agency failed to meet the standard provided by statute and articulated by the courts. It failed to comply with § 553(c) of APA.

Upon the reasoning in and again based upon *St. James Hospital, supra*, and the other authorities cited with regard to the substantive contentions made by plaintiffs and not inconsistent therewith, this Court holds that:

A. 42 C.F.R. 405.452(b)(1)(ii) is violative of APA 5 U.S.C. § 706(2)(a) because the Agency action is arbitrary, capricious, an abuse of discretion and not in accordance with law; and

B. That the subject regulation as promulgated violates the Medicare statute and that it is neither rational, non-arbitrary nor does it further the purpose of the Medicare statute.

This ruling does not preclude the Secretary from considering and adopting changes to the pre-July 1, 1979 procedure and practice, if made in accordance with law, both procedurally and thereafter substantively comporting with the authority conferred under the Medicare statute. Thereupon, this matter is REMANDED to the Secretary for further consideration in accordance with this Opinion. Further, the defendants' motion to strike affidavits is GRANTED.

DONE AND ORDERED in Chambers at Miami, Southern District of Florida, this 24 day of SEPTEMBER, 1984.

/s/ SIDNEY M. ARONOVITZ

Sidney M. Aronovitz
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO: 83-1700-Civ-ARONOVITZ

PARKWAY MEDICAL CENTER; PALM BEACH GARDENS COMMUNITY HOSPITAL; CLEARWATER COMMUNITY HOSPITAL; AND AMISUB OF FLORIDA, PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF THE DEPT. OF HEALTH & HUMAN SERVICES; AND CAROLYNE K. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEFENDANTS

CASE NO: 83-1005-Civ-ARONOVITZ

BAPTIST HOSPITAL OF MIAMI; ABBEY HOSPITAL AND MEDICAL CENTER; BASCOM PALMER EYE INSTITUTE; BETHESDA MEMORIAL HOSPITAL; BOCA RATON COMMUNITY HOSPITAL; BROWARD GENERAL MEDICAL CENTER; CEDARS MEDICAL CENTER; DOCTORS GENERAL HOSPITAL; DOCTORS HOSPITAL OF LAKE WORTH; FLORIDA KEYS MEMORIAL HOSPITAL; FLORIDA MEDICAL CENTER; HIGHLANDS GENERAL HOSPITAL; HOLY CROSS HOSPITAL, INC.; IMPERIAL POINT MEDICAL CENTER; JACKSON MEMORIAL HOSPITAL; JAMES ARCHER SMITH HOSPITAL; LARKIN GENERAL HOSPITAL; LOS OLAS GENERAL HOSPITAL; MARTIN MEMORIAL HOSPITAL; MERCY HOSPITAL, INC.; NORTH BROWARD HOSPITAL; PALM BEACH-MARTIN COUNTY MEDICAL CENTER; PEMBROKE PINES GENERAL HOSPITAL; WALKER MEMORIAL HOSPITAL, PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

ORDER DENYING MOTIONS TO DISMISS

THIS CAUSE was considered upon two separate and independent motions to dismiss submitted by the defendant herein. The first of these motions, which will be described as the defendant's *second* motion to dismiss, seeks dismissal for alleged lack of jurisdiction for failure to file claims in this Court within the time limitation in 42 C.F.R. § 1395(f). The next motion to dismiss, which will be referred to herein as the *third* motion to dismiss, attacks the appeals only of plaintiffs Mercy Hospital and Abbey Hospital and Medical Center upon the basis that these plaintiffs allegedly did not perfect their appeals from the fiscal intermediary to the Provider Reimbursement Review Board. That Board refused to certify those parties' claims for review to this Court.

This Court has carefully considered the memoranda of law submitted in support of each motion to dismiss, the responses thereto, each respectively, and pertinent portions of the record, and being otherwise fully advised in the premises, it is thereupon

ORDERED AND ADJUDGED as follows:

1. Defendant's motion to dismiss founded upon lack of jurisdiction for failure to file their Complaints herein within sixty (60) days of receiving notice filed by the Provider Reimbursement Review Board be, and the same is hereby DENIED (the *second* motion to dismiss); and,

2. Defendant's motion to dismiss addressed to the claims of Mercy Hospital and Abbey Hospital and Medical Center grounded upon those plaintiffs' alleged failure to perfect their appeals from the fiscal intermediary to the Provider Reimburement Review Board be, and the same is hereby DENIED (the *third* motion to dismiss).

With regard to the second motion to dismiss, 42 C.F.R. § 1395(f) requires that providers shall exercise their right to jurisdictional review of fiscal intermediaries' determinations in expedited review cases by commencing action within sixty (60) days of the date on which the Provider Reimbursement Review Board determines that it is without authority to decide the question. *See* 42 U.S.C. § 1395oo(f). On February 18, 1983, the Provider Reimbursement Review Board issued a notice that it lacks the authority to determine the validity of the malpractice regulation and granted the group of providers permission to proceed to Federal Court on an expedited basis. This applied to the plaintiffs Baptist Hospital of Miami, *et al.*, and those plaintiffs in Case Number 83-1005-Civ-ARONOVITZ. Plaintiffs filed this action on April 22, 1983—sixty-three (63) days after that determination was issued. With regard to plaintiff Parkway Regional Medical Center and the plaintiffs in Case Number 83-1700-Civ-ARONOVITZ, the Provider Reimbursement Review Board rendered its decision and issued its letter on May 3, 1983. Plaintiffs filed their action on July 6, 1983—sixty-four (64) days later.

Defendants contend that 42 USC § 1395oo(f)(1) provides that providers may seek judicial review of a final decision "within sixty (60) days of the date on which notice of any final decision by the Board, or of any reversal, affirmance or modification by the Secretary is *received*" [emphasis added]. The statute in the same section later used the term "rendered".

Plaintiffs contends:

> "A. That § 1395oo(f)(1) is not clear upon its face; that 'rendered' need not necessarily be defined to mean the date the notice is issued, and can mean as well the date the decision is announced to the provider, *i.e.*, upon receipt.

"B. It is uncontroverted that the letter sent by the Provider Reimbursement Review Board (the statutory notice) stated that the Provider had sixty (60) days from receipt in which to file judicial action. It is uncontroverted that both actions were filed within that time period.

"C. It is the standard practice of the Provider Reimbursement Review Board that a determination is rendered upon receipt of notice.

"D. The Secretary here applies principles of statutory construction to the subject statute in an inconsistent manner; that is, the Secretary is highly flexible on other timing requirements and yet not here in this instance."

Those Courts which have reviewed this same motion to dismiss when it was opposed by the plaintiffs have unanimously denied it. *See Lloyd Noland Hospital and Clinic v. Heckler*, no. CV83-PT-0868-S, (N.D. ALA. April 6, 1984) (Propst, J.); and *Alexandria Hospital v. Heckler*, no. 83-0233-R (E.D. Va. May 7, 1984) (Merhige, J.); and others. This Court finds and holds that the intent of the statute and of the Congress was that the sixty-day period commences upon the date of "receipt" of the notice. In *Mathews v. Eldridge*, 424 U.S. 319, 328 n.9, 96 S.Ct. 893, 899 (1976); and *Weinberger v. Salfi*, 42 U.S. 749, 763-64, 95 S.Ct. 2457, 2466 (1975), the Supreme Court specifically held that the sixty-day appeal period found in 42 U.S.C. § 405(g) was only a statute of limitations and could be waived by the parties if not timely raised. It is well-established that jurisdictional analysis for provider claims in the Medicare Program is controlled by the principles and precedents developed in Title II context. *See V.N.A. of Greater Tift County, Inc. v. Heckler*, 711 F.2d 1020, 1024 (11th Cir. 1983), *petition for cert. docketed*, No. 83-984 December 5, 1983, *Eldridge* and *Salfi, supra*. These principles are likewise applicable here

to a situation which does *not* involve a waiver as to *subject matter jurisdiction.* Accordingly, the motion to dismiss is DENIED and defendant's motion alternatively to amend affirmative defenses and add that of statute of limitations is hereby DENIED AS MOOT.

Addressing defendant's third motion to dismiss, defendant claims that plaintiffs Mercy Hospital and Abbey Hospital and Medical Center did not perfect their claims before the Provider Reimbursement Review Board. In its February 18, 1983 decision certifying for expedited judicial review under 42 U.S.C. § 1395oo(f)(1), the entire group of providers was so certified with the exception of the claims of Mercy and Abbey. These were subject to a separate decision in which the Board held that it had no jurisdictional authority over the claims of these plaintiffs because they had failed to claim in their cost reports the costs for which they now claimed review. In fact, both Mercy and Abbey filed cost reports as required by the Medicare statute regulation, and malpractice insurance costs here at issue were matters "covered by such cost reports" within the meaning of the Medicare statute. Because hospital administrators for these hospitals were reluctant to file claims specifically designating cost amounts alleged to be violative of the statute because counsel believed that to do so might subject them to criminal charges for fraud, does not diminish or in any way dilute the fact that Mercy and Abbey both in fact did file their "cost reports" as required and within those reports was contained the basis for contest and reimbursement for inaccurately or improvidently determined allowances.

There is no statutory requirement that in the course of filing the "cost report" that a provider must also "raise an issue". The report itself is a voluminous document with schedules, worksheets and supplemental worksheets. The Provider Reimbursement Review Board specifies which

schedules and worksheets must be filled and the phrase "matters covered by such cost report" certainly includes costs of malpractice insurance which must be at least three constituent worksheets. Thus they are within the jurisdiction of the Board so long as they were "covered by such cost report". It is understandable that since the cost report itself warns that misrepresentations of data on the cost report may be punishable by fine or imprisonment, that thereupon some hospital administrators would choose to follow the Agency's instructions and effectuate a self-disallowance. They therefore could expect to litigate a jurisdictional issue rather than defend against charges of fraudulent misrepresentation. The Courts have consistently held that a specific notice of dispute is not itself necessary and that a self-disallowance is adequate.

The case falls squarely within the purview of *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 104 S.Ct. ____ (1983); *Community Hospital of Raonoke Valley* [*sic*] *v. Heckler*, No. 83-0718-R (W.D. Va. April 24, 1984) (Attachment C); and *Our Lady of Lourdes Memorial Hospital v. Schweiker*, No. 80-CV-226 (N.D.N.Y. July 26, 1982), *reprinted in CCH Medicare and Medicaid Guide*, ¶ 32,154 (Attachment D); *see also Memorial Hospital v. Schweiker*, No. 80-67-Civ-Y (M.D. Fla. October 20, 1983) *reprinted in CCH Medicare and Medicaid Guide*, ¶ 31,603 (Attachment E), *aff'd sub nom. Memorial Hospital v. Heckler*, 706 F.2d 1130 (11th Cir. 1983). In each of those cases, the hospitals in question included the costs at issue (patient telephone or Hill-Burton "free care" costs in *St. Mary* and *Memorial*; labor and delivery room costs in *Community Hospital*; and physician compensation costs in *Our Lady of Lordes*) on Worksheet A and effectuated "self-disallowances" through completion of other appropriate worksheets.

In *St. James Hospital v. Harris*, 535 F.Supp. 751 (N.D. Ill. 1981), the District Court found that a self-disallowance was sufficient to satisfy the jurisdictional prerequisites of 42 U.S.C. § 1395oo, 535 F.Supp. at 760-61. The Court characterized the Agency's position as a "hypertechnical construction of the statute and regulations. . . . The statute does not make an adjustment by the Intermediary a requirement for jurisdiction of the Board." *Id.* at 760.

In *St. Mary of Nazareth*, the Court of Appeals affirmed the jurisdictional ruling of the District Court in *St. James Hospital v. Harris*, stating:

> [T]he Secretary also contends that the Provider Reimbursement Review Board was without jurisdiction . . . because the hospital itself had "self-disallowed" the costs when they filed worksheet A-8 of their Medicare Cost Report. The Secretary takes the position that the relevant statutes require an initial presentation of the question . . . to the fiscal intermediary before the hospital is entitled to a hearing by the Provider Reimbursement Review Board.

698 F.2d at 1346. After quoting the language of 42 U.S.C. § 1395oo(d), the Court described it as vesting "broad authority" to review and adjust the cost report:

> As the statute itself expressly states, the Board may consider any matter "even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d). Therefore, since the statute allows the Board to consider matters outside of the cost reports, we hold the Provider Reimbursement Review Board has the authority to consider whether the costs of providing Medicare patients with bedside telephones are reimbursable expenses under the Medicare Act.

698 F.2d at 1346.

In *Our Lady of Lourdes Memorial Hospital v. Schweiker*, the Agency argued that the Provider Reimbursement Review Board had no jurisdiction over a self-disallowed cost because there was no cost "claimed". The Court rejected the Agency's position as "belied by the plain language of the statute", and noted that "it is not in the Secretary's best interest to penalize a provider that makes good faith effort to comply with Medicare's myriad rules, regulations, and manuals by placing it in the . . . unfortunate position [of having to violate those rules in order to protect appeal rights]." *Slip op.* (as reprinted) at 10,565-10,566.

In *Memorial Hospital, Inc. v. Schweiker*, the District Court held that self-disallowed costs constitute "matters . . . not considered by the intermediary" within 42 U.S.C. § 1953oo(d), and that the Provider Reimbursement Review Board has jurisdiction to review such costs. *Slip op.* (as reprinted) at 9921. On appeal, the Court of Appeals implicitly rejected the jurisdictional challenge by proceeding to the merits of that case. *Memorial Hospital v. Heckler*, 706 F.2d 1130 (11th Cir. 1983).

In *Community Hospital of Roanoke Valley*, the Court held that "neither the act, nor the applicable regulations require a provider to violate agency policy. . .. [A]n adjustment by the intermediary is not required for jurisdiction." *Slip op.* at 7.

Accordingly, both the second and third motions to dismiss are DENIED, each respectively, as addressed to each party named herein.

DONE AND ORDERED in Chambers at Miami, Southern District of Florida, this 24 day of SEPTEMBER, 1984.

/s/ SIDNEY M. ARONOVITZ

Sidney M. Aronovitz
United States District Judge

APPENDIX D

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO: 83-1700-Civ-ARONOVITZ

PARKWAY MEDICAL CENTER; PALM BEACH GARDENS COMMUNITY HOSPITAL; CLEARWATER COMMUNITY HOSPITAL; AND AMISUB OF FLORIDA, PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF THE DEPT. OF HEALTH & HUMAN SERVICES; AND CAROLYNE K. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEFENDANTS

CASE NO: 83-1005-Civ-ARONOVITZ

BAPTIST HOSPITAL OF MIAMI; ABBEY HOSPITAL AND MEDICAL CENTER; BASCOM PALMER EYE INSTITUTE; BETHESDA MEMORIAL HOSPITAL; BOCA RATON COMMUNITY HOSPITAL; BROWARD GENERAL MEDICAL CENTER; CEDARS MEDICAL CENTER; DOCTORS GENERAL HOSPITAL; DOCTORS HOSPITAL OF LAKE WORTH; FLORIDA KEYS MEMORIAL HOSPITAL; FLORIDA MEDICAL CENTER; HIGHLANDS GENERAL HOSPITAL; HOLY CROSS HOSPITAL, INC.; IMPERIAL POINT MEDICAL CENTER; JACKSON MEMORIAL HOSPITAL; JAMES ARCHER SMITH HOSPITAL; LARKIN GENERAL HOSPITAL; LOS OLAS GENERAL HOSPITAL; MARTIN MEMORIAL HOSPITAL; MERCY HOSPITAL, INC.; NORTH BROWARD HOSPITAL; PALM BEACH-MARTIN COUNTY MEDICAL CENTER; PEMBROKE PINES GENERAL HOSPITAL; WALKER MEMORIAL HOSPITAL, PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

FINAL JUDGMENT

THIS COURT, under even date herewith, has entered a Memorandum Opinion and Order Granting Plaintiffs' Motions for Summary Judgment and Denying Defendants' Cross-Motions for Summary Judgment. In accordance therewith and for the reasons therein stated, it is thereupon

ORDERED AND ADJUDGED by way of Final Judgment that the following rights of the parties are hereby declared and adjudicated:

A. The subject malpractice rule was not promulgated in violation of the notice and comment provisions of 5 U.S.C. § 553;

B. The subject regulation was not promulgated with an adequate basis and purpose statement with the malpractice regulation, and failed to comply with § 553(c) of the Administrative Procedure Act;

C. 42 C.F.R. § 405.452(b)(1)(ii) is arbitrary, capricious, an abuse of discretion, not in accordance with law, and is therefore substantively invalid under 5 U.S.C. § 706(2)(a);

D. The subject regulation as promulgated violates Medicare § 1395x(v)(1)(a) and is neither rational, non-arbitrary nor does it further the purpose of the Medicare statute;

E. By reason of the aforegoing, the subject regulation is hereby declared to be invalid, and this matter is REMANDED to the Secretary for further consideration in accordance with this Opinion;

F. Plaintiffs are hereby awarded costs of this action to be taxed by the Clerk of this Court upon the filing of a Bill of Costs.

DONE AND ORDERED in Chambers at Miami, Southern District of Florida, this 24 day of SEPTEMBER, 1984.

/s/ SIDNEY M. ARONOVITZ
Sidney M. Aronovitz
United States District Judge

APPENDIX E

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 83-1700-Civ-Aronovitz

PARKWAY GENERAL REGIONAL MEDICAL CENTER, ET. AL., PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

CASE NO. 83-1005-Civ-Aronovitz

BAPTIST HOSPITAL OF MIAMI, ET. AL., PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

ORDER DENYING MOTION FOR RECONSIDERATION

THIS CAUSE came before the Court upon Defendant's Motion for Reconsideration of Judgment Denying the Secretary's Motion to Dismiss the Claims of Mercy Hospital, Abbey Hospital and Medical Center for Lack of Jurisdiction (filed October 4, 1984). The Court has carefully considered the motion, the supporting and opposing memoranda thereto, the pertinent portions of the record (including the Order Denying Defendant's Motion to Dismiss entered September 24, 1984), the applicable law and being otherwise fully advised in the premises, it is

ORDERED AND ADJUDGED that said motion be, and the same is, hereby DENIED.

Defendant's Motion for Reconsideration is based on three recent decisions from Circuit Courts outside of the Eleventh Circuit. Two of these decisions were previously considered by this Court in its initial determination of the Motion to Dismiss for Lack of Jurisdiction. *Athens Community Hospital, Inc., et. al v. Richard S. Schweiker, Secretary of Health and Human Services,* No. 81-1807; *Hospital Corporation of of America v. Richard S. Schweiker, Secretary of Health and Human Service* No. 81-1814 (D.C. Cir. August 28, 1984) (hereinafter "Athens") and *Saint Mary of Nazareth Hospital Center, et. al. v. Richard S. Schweiker,* No. 82-1034; *Mount Zion Hospital and Medical Center v. Richard S. Schweiker,* No. 82-1047; *Washington, Township Hospital District d/b/a Washington v. Richard S. Schweiker,* (D.C. Cir. August 28, 1984) (hereinafter "St. Mary"). Moreover, the third case, *Saline Hospital Association et. al. v. Secretary of Health and Human Services,* No. 83-1184 (6th Cir. September 19, 1984) (attached to Defendant's Motion as Exhibit "C") is, like the *Athen* and *St. Mary* cases, factually distinguishable from the case at bar in that the disputed costs in each of those three cases were never before the intermediary in any fashion. As this Court found in its initial opinion of September 24, 1984, the medical malpractice insurance costs at bar were within categories of costs which were contained in the hospitals' filed cost reports and presented to the intermediary. As such, this Court had jurisdiction to consider the instant cause.

DONE AND ORDERED in Chambers at Miami, Florida, this 18 day of December, 1984.

/s/ SIDNEY M. ARONOVITZ

Sidney M. Aronovitz
United States District Judge

cc: All counsel of record

APPENDIX F

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA TALLAHASSEE DIVISION

TCA 83-1728-WS

TALLAHASSEE MEMORIAL REGIONAL MEDICAL CENTER, ET. AL., PLAINTIFFS,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

[Filed June 21, 1985]

ORDER

Before the court are various motions from both plaintiffs and defendant. The court will address each of these motions in turn. The court has reviewed the complete record with care and has considered all relevant material. It should be noted that we are not "going where no man has gone before," but are rather following a course well-charted by the federal judiciary. Indeed, the new rule at issue here has been invalidated recently by the Eleventh Circuit. *Lloyd Noland Hospital and Clinic v. Heckler,* Nos. 84-744, 84-8699 (11th Cir. June 12, 1985).

FACTS

This lawsuit arises under Title XVIII of the Social Security Act, the "Medicare" program, P.L. 89-97, 42 U.S.C. § 1395 *et seq.* The legislation provides for federal reimbursement to programs providing medical care for the elderly. Hospitals are reimbursed for reasonable and necessary costs or, if lower, the customary service charges.

Prior to the issuance of the malpractice rule change, 42 C.F.R. § 405.452(b)(1)(ii),[1] in 1979, hospitals were reimbursed for the cost of malpractice insurance based upon the ratio of Medicare patient utilization of hospital services to total patient utilization. This is the standard for most Medicare reimbrusement.

The challenged rule, which is an exception to the general rule for Medicare reimbursement, reimburses a hospital for the percentage of its malpractice insurance costs equal to the ratio of malpractice losses it has paid to Medicare beneficiaries to total malpractice losses paid to all patients.

Plaintiffs have challenged the rule on a number of grounds, including, procedural defects, promulgation without compliance with notice and comments and that the promulgation was arbitrary, capricious, and an abuse of discretion.

I. Defendant's Motion to Strike Plaintiffs' Affidavits

Defendant has filed a motion to strike plaintiffs' affidavits (document 29), contending that the affidavits were not available to the agency during rulemaking. The affidavits were prepared after the rule was published for submission to the administrative agency's review board as part of a challenge to the rule. The general rule is that a court is to review only the record in existence when the rule was developed. *F.P.C. v. Transcontinental Gas Pipe Line Corp.*, 423 U.S. 326, 331 (1976).

After carefully reviewing the record and the opinions of seven district courts that have granted defendants' motions to strike, this court grants defendant's motion to strike

---

[1] Renumbering of the Medicare regulations has occurred since 1979. The malpractice rule is now found at 42 C.F.R. § 405.452(a)(1)(ii)(1984).

and adopts the persuasive reasoning of the court in *St. James Hospital v. Heckler,* 579 F. Supp. 757 (N.D. Ill. 1984).

II. Defendant's Motion to Dismiss for Lack of Jurisdiction Plaintiffs Santa Rosa Hospital, Jackson County Hospital, and for the Cost Reporting Period 1980, Shands Teaching Hospital and Clinic

Defendant has filed the above-captioned motion to dismiss (document 31), contending that the three plaintiffs have not satisfied jurisdictional requisites for review because they failed to claim in their cost reports the costs for which review was sought. "[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review." *Memorial Hospial v. Heckler*, 706 F.2d 1130, 1133 (11th Cir. 1983).

The court having reviewed the extensive materials filed by both parties and the reasoned opinion of the court in *Parkway Medical Center v. Heckler*, 83-700 (S.D. Fla. 1984), denies defendant's motion to dismiss for lack of jurisdiction.

III. Defendant's Motion to Dismiss

Defendant has filed a motion to dismiss this action for lack of subject-matter jurisdiction (document 41). Defendant contends that the statutory jurisdictional prerequisite for review of this case is the commencement of an action within sixty days of the date of a determination by the Department of Health and Human Services Provider Reimbursement Review Board that the Board is without authority to decide the question and that the plaintiffs have not filed within the mandated time period. Plaintiffs contend that the sixty-day filing period is not a prerequisite to this court's subject-matter jurisdiction, but is rather a statute of limitations which may be and was waived by the defendant. The time limitations for filing

suit under the Social Security Act are statutes of limitation, and not prerequisites to jurisdiction. Decisions interpreting the Social Security Act provisions control similar issues arising under the Medicare Act. *V.N.A. of Greater Tift City, Inc. v. Heckler*, 711 F.2d 1020, 1024 (11th Cir. 1983).

This court has reviewed and considered all documents relating to this motion. The Eleventh Circuit in *Lloyd Noland* declared the 60-day period a statute of limitation, and therefore this court has subject matter jurisdiction. *Lloyd Noland* at 5.

IV. Plaintiffs' Motion for Partial Summary Judgment and Defendant's Cross-Motion for Summary Judgment

Plaintiffs have moved for summary judgment with respect to Counts I, II, V, VI, and VII of the complaint (document 24), and defendant has filed a cross-motion for summary judgment (document 28).

The court has reviewed the record with care and deliberation. At last count, twenty-four district courts and five courts of appeals have addressed the challenges to the malpractice rule presented here. Although four district courts have upheld the rule, one case has been reversed on appeal and another has been remanded for further development of the rulemaking record. The vast majority of courts have invalidated the malpractice rule.

This court can add little to the reasoning and analysis of the courts that have considered the rule. This court finds the majority position most persuasive, and indeed the binding precedent of the Eleventh Circuit compelling. Therefore, plaintiffs' motion for partial summary judgment is granted. Defendant's cross-motion for summary judgment is denied.

Accordingly, it is ORDERED that:

I. Defendant's motion to strike plaintiffs' affidavits is GRANTED.

II. Defendant's motion to dismiss for lack of jurisdiction plaintiffs Santa Rosa Hospital, Jackson County Hospital, and for the cost reporting period 1980, Shands Teaching Hospital and Clinic is DENIED.

III. Defendant's motion to dismiss for lack of subject-matter jurisdiction is DENIED.

IV. Plaintiffs' motion for partial summary judgment is GRANTED.

V. Defendant's motion for summary judgment is DENIED.

VI. Plaintiffs shall confer with counsel for the Secretary and shall file a stipulated status report with the court within twenty (20) days of the date of this order.

DONE AND ORDERED this 20th day of June, 1985.

/s/ WILLIAM STAFFORD
William Stafford
Chief Judge

APPENDIX G

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA TALLAHASSEE DIVISION

TCA 83-7128-WS

TALLAHASSEE MEMORIAL REGIONAL MEDICAL CENTER, ET. AL., PLAINTIFFS,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

[Filed Aug. 29, 1985]

ORDER & FINAL JUDGMENT

Before the court is defendant's motion to stay proceedings with memorandum in support (document 66). The asserted grounds for a stay are that the Secretary is seeking further appellate review of several adverse decisions. Because there is no reason for this court to assume that defendant will prevail on these appeal, the motion is DENIED.

For the reasons more fully set forth in *Lloyd Noland Hospital and Clinic v. Heckler*, Nos. 84-7444 and 84-8699 (11th Cir. June 12, 1985), this court finds that the challenged regulation, 42 C.F.R. § 405.452(b)(1)(ii) (1979), is arbitrary and capricious in violation of 5 U.S.C. §§ 706(2)(A) and (C) and was promulgated in violation of 5 U.S.C. § 553(c).

This matter is hereby remanded to the Provider Reimbursement Review Board for payment of the plaintiff hospitals' malpractice insurance costs pursuant to 42

C.F.R. § 405.452(b)(1)(1979) without reference to the malpractice rule, 42 C.F.R. § 405.452(b)(1)(ii)(1979).

DONE AND ORDERED this 29th day of August, 1985.

/s/ WILLIAM STAFFORD
William Stafford
Chief Judge

APPENDIX H

DEPARTMENT OF HEALTH AND
HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
793 ELKRIDGE LANDING ROAD
LINTHICUM, MARYLAND 21090

Refer to
JB:81-418G

Location Airport Investment Building
Room 245, South Plaza
Telephone: 301-859-5820
FEB. 18, 1983

Certified Mail

Margaret Manning, Esquire
Ober, Grimes & Shriver
1600 Maryland National Bank Building
Baltimore, Maryland 21202

Dear Ms. Manning:

Re: Florida Malpractice Group Appeal,
Case No. 81-418G

The Board has reviewed the record in the above-captioned case and finds there is no jurisdictional authority concerning the malpractice issue for the providers listed on the enclosure in the Florida Malpractice Group Appeal. This finding is based upon the fact that the malpractice issue was not raised in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

Pursuant to the controlling law and regulations (42 USC section 1395oo and 42 CFR 405, subpart R), the Board is empowered to review and hold hearings concerning final determination of fiscal intermediaries (i.e., NPR) regarding Medicare provider cost reimbursement. The jurisdictional requirements to secure a Board hearing are set forth in 42 USC section 1395oo(a) and (b).

Title 42 USC section 1395oo provides:

> "(a) *Any provider of services which has filed a required cost report* within the time specified in regulations *may obtain a hearing with respect to such cost* report by a Provider Reimbursement Review Board (hereinafter referred to as 'the Board') which shall be established by the Secretary in accordance with subsection (h), *if*–
>
> (1) such provider–
>
> (A) *is dissatisfied with a final determination* of the organization serving as *its fiscal intermediary* . . . as the amount of total program reimbursement due the provider for the period *covered by such report*, . . .
>
> (2) the *amount in controversy* is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination. . . .
>
> (b) The provisions of subsection (a) shall apply to any group . . . if the matters in controvery involves a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more." (Emphasis added)

The regulation, 42 CFR 405.1839(a), provides the methodology of determinining the $10,000 amount in controversy a follows:

> "The $10,000 *amount in controversy* will be computed by deducting the adjusted total reimbursable program costs from the total reimbursable cost . . . *claimed* by the provider." (Emphasis added)

The cited statutory provisions clearly entitle a provider to a Board hearing only with respect to a cost report which was filed in compliance with the rules and regulations of the Secretary. The Board's jurisdiction is limited to issues when the provider ". . . is dissatisfied with a final determination (NPR) of its intermediary . . ." on matters covered by such filed cost report; and the request for hearing is made within 180 days of the NPR. The statutory phrases ". . . dissatisfied with a final determination of its intermediary . . .", ". . . amount in controversy . . .", and ". . . covered by such cost report . . ." certainly indicate that a provider must have made an overt disclosure (notice) of its posture on a particular issue which ordinarily would be evidenced by claiming reimbursement for the particular item on the cost report.

The regulations clearly require that, as a condition precedent, the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item which especially applies to self-disallowed costs. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. Thus, the Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report, and the disputes arising from costs claimed in the cost report.

The provider's entitlement to a hearing is conditioned upon the three subsections immediately following the word 'IF" of the basic section—see 42 USC 1395oo(a) cited above. Accordingly, the statutory language *does require* "dissatisfaction" with the intermediary's final determination and for a controversy to exist. When the provider files a cost report, the particular cost must be claimed therein or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination which was not done in this case. This is essential to Board jurisdiction.

The statute does not entitle a provider to claim additional reimbursement for a particular cost reporting period after filing its cost report nor after receiving the intermediary's final determination (NPR). However, once a cost report is filed, the regulations provide that any amendments to the cost report ". . . may be permitted or required as determined by the Health Care Financing Administration, ..." (42 CFR section 405.453(f)) HCFA policy instructions stated in Pt. 2—Part A Intermediary Manual, section 2631.2 (HIM-13-2), contains the criteria in the limited situations where the intermediary may accept an amended cost report. Once an intermediary has issued a final determination (NPR) regarding a provider's filed cost report, a cost report may only be amended if the intermediary "reopens" its final determination. Accordingly, the reopening provisions of the regulations are controlling, 42 CFR section 405.1885(a), and jurisdiction for such reopenings rests exclusively with that administrative body that rendered the last determination (which in this case was the intermediary) (42 CFR section 405.1885(c)). (See *Athens Community Hospital, Inc., et. al., v. Richard S. Schweiker, Secretary of Health and Human Services*, United States Court of Appeals for the District of Columbia Circuit, No. 81-1807, August 27, 1982.)

The Athens court (supra) stated:

> "Reopening is thus allowed only to hear new evidence—not new claims. Moreover, under 42 CFR section 405.1885(c), jurisdiction to reopen "rests exclusively with that administrative body that rendered the last determination or decision"; in other words if the fiscal intermediary decides not to reopen, the decision is not appealable to the PRRB."

Section 405.1885(c) of the regulations states that ". . . jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Section 405.453(f) also provides that ". . . amended cost report information which has been previously submitted by a provider *may be permitted* or required as determined by the Health Care Financing Administration." The Medicare Bureau's (formerly Bureau of Health Insurance) policy (HIM 13, Part 2) further adds "Whether or not the Intermediary will reopen a determination . . . which is otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or guidelines."

The above authorities provide: (1) that the acceptance of an amended cost report is within the discretion of the intermediary, and (2) that once an NPR has been issued, then the reopening (including through an amended cost report) is within the exclusive jurisdiction of the intermediary which is not appealable per se.

The Board's jurisdiction flows from the cost report or amended cost report and the related NPR or revised NPR. There must have been a claim on the cost report or amended cost report that ultimately gives rise to the dis-

agreement. Thus, Board jurisdiction is limited to those cases in which a provider has claimed a reimbursement amount and the intermediary has denied that claim in full or in part. Title 42 USC 1395oo(d) provides:

> "The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make other revisions on matters *covered by such cost report* (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

The Athens Court stated:

> "This provision is clearly limited to revisions of matters covered by the original cost report and does not authorize the Board to consider new claims. Such a conclusion is reinforced by 42 USC section 1395oo(a) which similarly limits PRRB review to matters raised by the original cost report."
>
> "Nor do the Medicare regulations provide a basis for such review. The language in 42 CFR section 405.1869 is virtually identical to that in 42 USC section 1395oo(d) . . . and the scope of the regulation is accordingly limited to 'matters covered by (the original) cost report.' "

It is equally clear, therefore, that the Board, in reaching a decision, may go beyond just the matters which were considered by the intermediary in making its final determination but that such expansion is limited to "matters covered by such cost report." A number of providers have asked that they be allowed to introduce into Board hearings various additional reimbursement items which they had never claimed and which their intermediaries had, therefore, never adjusted or disallowed. Neither the law nor the Board's exercise of this section 1395oo(d) authority in limited cases contemplated any substantial prolifera-

tion. No consideration will be given to any request for a hearing which does not comply with the foregoing minimal requirements and no expansion of the scope of the appeal or the hearing will be allowed to include any other issue or amount not originally claimed. This determination is subject to the provisions of 42 USC 1395oo(f).

Board Members Participating:
Thomas M. Tierney
James Houdek, Jr., CPA
Bette A. Kraus
Paul Morton Ganeles, CPA
Richard A. Dudgeon, CPA

FOR THE BOARD:

/s/ THOMAS M. TIERNEY
Thomas M. Tierney
Chairman

Enclosure

cc:
Irwin Cohen, Esquire, Attorney Advisor's Office
Mr. John P. Ruocco, Blue Cross and Blue Shield Association
Mr. Jerry W. Chambers, Blue Cross/Blue Shield of Alabama
Mr. Lawrence R. Beutlich, Blue Cross of Florida, Inc.
Mr. Dan T. Gregorio, Health Care Service Corporation
Mr. Terry Hamaker, Mutual of Omaha

ISSUE: COSTS OF MALPRACTICE INSURANCE
Case No. 81-418G

FLORIDA HOSPITAL
GROUP APPEAL

NUMBER	PROVIDER NAME	DATE OF NPR	DATE OF HEARING REQUEST	COST REPORTING PERIOD-FYE	FISCAL INTERMEDIARY	AMOUNT OF MEDICARE REIMBURSEMENT IN CONTROVERSY	AUDIT ADJUSTMENT NUMBER
00-0061	Mercy Hospital, Inc.	09/30/81	12/28/81	08/31/80	Blue Cross/Blue Shield of Fla.	$52,800	*
10-0099	Lake Wales Hospital	09/30/82	11/15/82	09/30/80	Blue Cross/Blue Shield of Fla.	36,410	*
10-0113	Shands Teaching Hospital & Clinic	02/26/82	07/21/82	06/30/80	Blue Cross/Blue Shield of Fla.	34,164	*
10-0124	Santa Rosa Hospital	02/26/82	07/21/82	09/30/80	Blue Cross/Blue Shield of Fla.	24,324	*
10-0142	Jackson County Hospital	09/17/82	11/15/82	09/30/80	Blue Cross/Blue Shield of Fla.	15,302	*
10-0152	Abbey Hospital and Medical Center	09/30/81	03/29/82	12/31/80	Blue Cross/Blue Shield of Fla.	7,881	*
10-0035	Manatee Memorial Hospital	09/30/82	01/24/83	09/30/81	Blue Cross/Blue Shield of Fla.	25,147	*
10-0061	Mercy Hospital, Inc.	09/30/81	12/28/81	08/31/80	Blue Cross/Blue Shield of Fla.	52,800	*

APPENDIX I

United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

No. 85-3839

D.C. Docket No. 83-07128

TALLAHASSEE MEMORIAL CENTER, ET AL.,
PLAINTIFFS-APPELLEES

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

Appeal from the United States District Court for the Northern District of Florida

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No. 85-5131

D.C. Docket Nos. 83-1005 & 83-1700

BAPTIST HOSPITAL OF MIAMI, ET AL.,
PLAINTIFFS-APPELLEES, CROSS-APPELLANTS

v.

OTIS BOWEN, SECRETARY OF HEALTH & HUMAN SERVICES,
DEFENDANT-APPELLANT, CROSS-APPELLEE

PARKWAY MEDICAL CENTER, PALM BEACH GARDENS COMMUNITY HOSPITAL, CLEARWATER COMMUNITY HOSPITAL, AND AMISUB OF FLORIDA,
PLAINTIFFS-APPELLEES/CROSS-APPELLANTS

v.

OTIS BOWEN, ETC., ET AL.,
DEFENDANTS-APPELLANTS/CROSS-APPELLEES

Appeals from the United States District Court for the Southern District of Florida.

JUDGMENT

Before CLARK, EDMONDSON and KEITH*, Circuit Judges.

These causes came on to be heard on the transcript of the record from the United States District Courts for the Northern and Southern Districts of Florida, and were argued by counsel;

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the judgment of the said District Courts in these causes be and the same are hereby, AFFIRMED; and that these causes be and the same are hereby, REMANDED to said District Courts for further proceedings in accordance with the opinion of this Court;

It is further ordered that each party bear their own costs on appeal.

Entered: May 5, 1987
For the Court: Miguel J. Cortez, Clerk
By: /s/ DAVID MALARID
Deputy Clerk

ISSUED AS MANDATE: JUN 23, 1987

EDMONDSON, Circuit Judge, concurred in part and dissented in part and filed an opinion.

*Honorable Damon J. Keith, U.S. Circuit Judge for the Sixth Circuit, sitting by designation.

APPENDIX J

42 U.S.C. (& Supp. III) 1395*oo* provides in pertinent part:

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

* * * * *

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * * * *

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the

provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District

Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * * * *

U.S. GOVERNMENT PRINTING OFFICE: 1987—181-483/40300